100

003

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01789 CERTIFICATE OF DEATH Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Carroll MARYLAND Maryland Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 days Salisbury Henryton

	d. NAME OF HOSPITA	AL (If not in hospital, g	ive street	address)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?							IDENCE			
	OR INSTITUTION	Henryton	Stat	e Hospital	}	405	Comme	rce	Stree	t			NO A		
3.	NAME OF DECEASED	Fir		Middle		Lost	4. DATE		Mont	th	Do	7	Year		
	(Type or print)	Char	les	Jackso	on	Barkley	DEATI	H Fet	ruary	7	10		1960		
5.	SÉX-	6. COLOR OR RACE	7. MARR	RIED NEVER MARRIED	8. DA	TE OF BIRTH		19. AG	E (In years birthday)	IF UNDER	1 YEAR	IF UNDI	ER 24 HRS.		
	Male	Negro	WIDOWI	ED DIVORCED	7	-26-1900			59 yrs.	MONTHS	Days	HOURS	Willi,		
100	during most of work Landscape	ing life, even if retired	done 10b.	KIND OF BUSINESS OR INI	DUSTRY	11. SIRTHPLACE (See	_		elwar			S.	A.		
13.	FATHER'S NAME				14.	MOTHER'S MAIDEN									
		John Barkl	еу				Fa	nnie	Bark	ley					
	WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	INFOR	MANT			Addr	955					
	No			Unknown		Charles	Jack	son	Barkl	еу -	Pa	tien	t		
		TH [Enter only one co TH WAS CAUSED 8Y: IMMEDIATE CAUSE (o		ne for (a), (b), and (c).] Cardio	vas	cular ins	suffic	ienc	У		INTI	ERVAL SE	DEATH		
	002X	DUE TO													
	Canditions, if ar		Mo	derately adv	vanc	ed bilate	eral p	ulmo	nary	tbc.					
	couse (a), stoting t	DITE TO		abetes melli	tuc										
z	lying cause lost.) (c	-			DELATED TO THE TER	TAMBLE DICEA	SE CON	DITION CR	ENI INI DAD	T 1/-1 3	Q 1A/AC	AUTOPSY		
CATION	PART II. OTH	ER SIGNIFICANT CON	DITIONS	CONTRIBUTINO TO DEATH &	JULINO!	KEDAJED TO THE TEN	AMINAL DISCA	ISE CON	DITION GIV	CIN SN FAR	IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES NO				
L CERTIF	20g. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCUP	RRED. (En	ter nature of injury	in Port I ar Po	art II of i	lem 18.)						
MEDICAL	20c. TIME OF INJURY Hour a. m. p. m.	Y Month, Day, Yes	While of work	Not while	PLACE C foctory,	OF INJURY (Home, fo street, office bldg.,	orm, 20f. (Ci etc.)	ly ar lav	vn)	(0	County)		(State)		
	21. I certify the	at attended the	deceas	ed from August	22	. 19 58 , toFe	ebruar	y 10	1960	that I la	st say	v the d	eceased		
				60 , and that dec			AM, fram	the c		d on the		stated			
	ACTUAL SIGNATURE	lgars M.	Mcc.	nlary	M.D.	He	enryto					2-10			
	PHYSICIAN'S NAME (Type)	r. E. M. M	iacul	ans, Supt.		Henryton	n Stat	е Но	spita	al He	nry	ton,	Md.		
22	BURIAL, CREMATION	2- 14	19101	GLASS H.	OR CRE	MATORY CEM-	22d. LOC	ATION (City, town, o	or county)	Ald	(Stat	te)		
23.	FUNERAL DIRECTOR'S	SIGNATURE	(ADDRESS			EB 1 5	STRAR	24b. REG15	TRAR'S SIG					
	MOESTE.	D. 1014	4	JA 155 BHIZ	1	1 C DATE		-	Clu	hun g	Kinn	4			

VS A1S (4) 1SM 9/SB

Miles of Manufithm (45)

P-03/6

75

₹114-

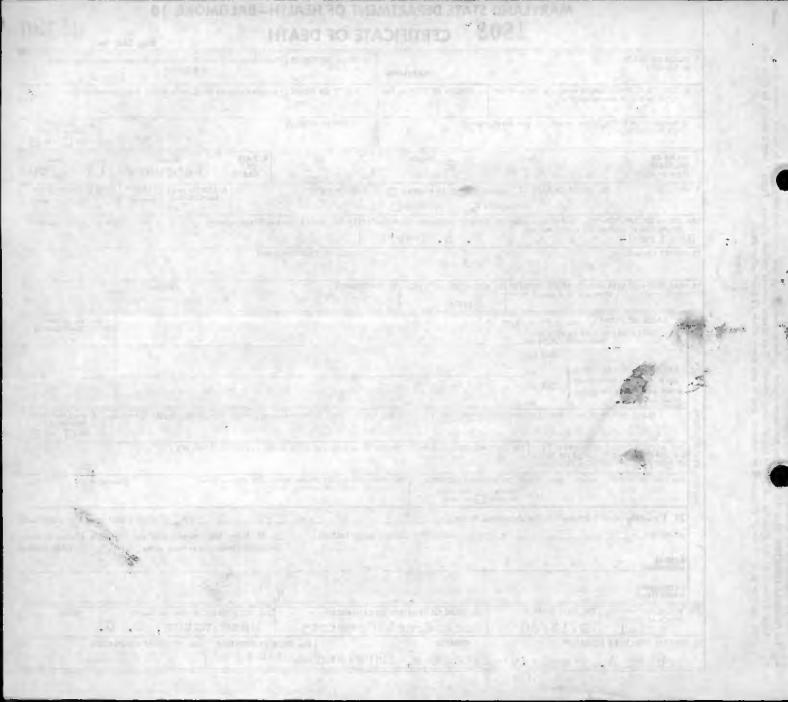
and the second second

EEQUASIO PLANTA MANAGEMENT

THE RESERVE OF THE PARTY OF THE

100

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



	me	4	П
1	65	1	=
1	Inn	1	

015

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH PLACE OF DEATH

	o. COUNTY _	oll	MARYLAND	CTATE					timor	
	RURAL and give ned	prest lown)	8yrs.7mos.26				its, write RU	RAL and giv	e negrest f	own)
	Loury of Down (if ounded corporate limith, write and start of the start in black of the start of the start in black of the start of th			10	RESIDENCE N A FARM? NO (34)					
	DECEASED				ey 4. g	OATE OF DEATH			Doy 15,	Yeor 19 60
5.		Tithita			, 1909	9. AGI	(In yeors birthdoy) O yrs.	Months D	YEAR IF UI	NDER 24 HRS. urs Min.
100	during most of worki	ing life, even if retired)	. KIND OF BUSINESS OR INDL			reign country)			S.A.	AT COUNTRY?
13.	FATHER'S NAME			14. MOTHER'S	MAIDEN NAME					
	Abraham	Bosley		Lylia	Hunter	mark				
	WAS DECEASED EVER	IN U. S. ARMED FORCES? 16	S. SOCIAL SECURITY NO. 17.		ld Host	oital R				
CERTIFICATION	Conditions, if on gove rise to im couse (o), storing the lying couse last. Postarill Old Postarill Old OR CONTRIBUTING OR CONTRIBUTING	DUE TO TO DE TO DE	contributing to peat the	· ICTE METER	TPSF2012	DISEASE CONI	DITION GIVI	EN IN PART)	WAC	
	Hour o.m.	While	e Not while fe			f. (City or low	n)	(Co	unly)	(Stole)
	saw the decease 220 FENATURE LOCALINATURE P2C PHYSICIAN'S NAMY (Type)	Agustin delCa	Carreformo, W.D.	death accurred Attending PHYS. 22d. Address Sprir	ol:30Pl	From the coor I STAN	s. □	ykesvi	date stat	22b. DATE SIGNED
-	REMOVAL (Specify)			OR CREMATORY						Stole)
24.			ADDRESS		25a. REC'D BY	REGISTRAR	25b. REGIS	TRAR'S SIGN	NATURE	7
	J.F.Eline	& Sons.Reist	erstown.Md.		DATE FER	1 9 '60	0	Y' 9	for a	

VR A15 (4) 15M 9/59

ATTACHED IN and altern him is a factor F -0 -0 + FF2 parties of the state of the sta - Ziell That - Lene The best of the The state of the s

	MAKT	LAND	CERTIFIC			I—BALIIM	OKE, 18		0179
		45	CERTIFIC	AIL OI L	LAII		Re	g. Dist. No.	
1. PLACE OF DEATH	arroll		MARYLAND	2. USUAL RESIL	aryla	ere deceased lived		Residence befo	100
b. CITY OR TOWN RURAL and give	(If outside corporate lim negrest town) Westminst		c. LENGTH OF STAY IN 16	c. CITY OR 1		otside corporete li		L and give nea	arest town)
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital,	ive street		d. STREET A		E. Main	Street		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	Gertru		Middle Holbrook	Bower		4. DATE OF DEATH	Month ebruary	y 13	
s. sex Female	6. COLOR OR RACE	7. MARR	DIVORCED	8. DATE OF BIRTI	. 187			INDER I YEAR Onlhs Doys	Hours Min.
during most of wo	ION (Give kind of work orking life, even if retired	done 105.	KIND OF BUSINESS OR INDE	USTRY 11. BIRTHPL	ACE (State o			12. CITIZEN O	S A
13. FATHER'S NAME	John Hel	broc	k	14. MOTHER'S		ame garet	(unknow	mm)	
IS. WAS DECEASED EV	/ER IN U. S. ARMED FOR	Innina		HEORMANT harles	H. Be	owers N	Address cstmins	ster.	Md.
590 × Conditions, if gave rise to code (a), stating lying couse last	any, which immediate but to		Aggartus						
	- '	-	ONTRIBUTING TO DEATH BU	T NOT RELATED TO	THE TERMIN	NAL DISEASE CON	IDITION GIVEN I	N PART 1(a) I	P. WAS AUTOPSY PERFORMED? YES NO
PART II. O	VAS UNDERLYING [] IG [] CAUSE OF DEATH Y MEDICAL EXAMINER]	206. DES	CRIBE HOW INJURY OCCURR	ED. (Enter noture o	f injury in P	ort I or Port II of	item 18.)		
ZOc. TIME OF INJU Hour a. m. p. m.	10	or 20d. If While of wor	Not while fo	PLACE OF INJURY (I actory, street, office			wn)	(County)	(State
21. I certify to alive an	than attended the	deceas 19	ed fram his	h accurred at	9125	a	causes and	on the da	te stated about DATE SIGN
PHYSICIAN'S NAME (Type)	W. C. Je	nnet	te, M.D.	10	3 E.	Main S	t. West	tminst	er, Md
220. BURIAL, CREMATI REMOVAL (Specifi Burial	ON, 226. DATE THEREO		22c. NAME OF CEMETERY OF Pleasant V		en.	22d. LOCATION (City, fown, or co		(State)
23, FUNERAL DIRECTO	R'S SIGNATURE		ADDRESS		240 PEC'D	RY PEGISTRAS	246 REGISTRA	P'S SIGNATUI	RE
John R.	Ryers We	at mi	noter Mery	hee I	DATE FE	B 1 6 60	Circh	un S. Pho	A CONTRACTOR OF THE PARTY OF TH

may be retained by the hospital or consistency.

O FUNERAL DIRECTOR: After this can also been signed by the attending physicion and campletely futed in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, ar removal, and in any event within 72 haurs offer death. hours after death. Page 4 N TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within my be retained by the hospital or of the page 3 should be detached for use of

X

• . The same of the THE RESERVE OF THE PROPERTY OF THE PARTY OF . To . Edition the state of the the second of the second of the second of the second

Westminster. Md.

NEB 1 5 '60

arthur S. Kraus

haurs after death.

VS A15 (4)

15M 9/58

1797 Seminorine of Dears

The state of the state of

Saffel of restriction, the

. I , or ear a least

				301-	
LIons	40	BINDER		Popular I	
	A	and anima on			
F 244		and properties		.a.s planyl	AR POMES
03	.50		malija desso	etan d	
	100		W W		
e e	the Feet		term outs public		na Seita Z
	177	metr stem		enfort.	Mercal:
und a clock as T	5802 moléki	windi rek me	vir 19 state	12	10.5
Metta.					
			The same		
A COMMENT					

ノ	· //\
Poge 4	director, sed with
÷	

tours ofter deal

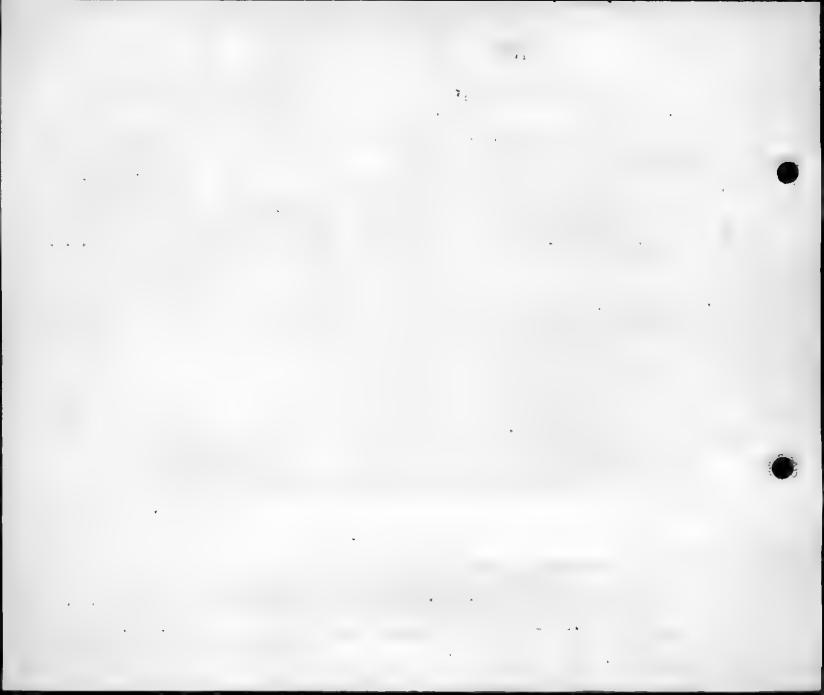
may be retained by the hospital or a sing physician.

TO FUNERAL DIRECTOR: After this certivicate has been signed by the attending physician and campletely filled in by the funer page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 boxes after death. 1. The law requires that the death certificate be executed within

TO HOSPITAL OR ATTENDING PHYSIC

VR A15 (4) 15M 9/59

1, PLACE OF DEATH o. COUNTY	arroll		MARYLI	- 11	USUAL RESIDENCE (V	Where decease yland	d lived if instituti b. COUNTY			
6 CITY OR TOWN RURAL and give	(If outside corporate limit nearest town)	ts, write	c LENGTH OF STAY IN		c. CITY OR TOWN (II	f outside corp	prote limits, write f	URAL ond	give negrest t	own)
3; kesvi.	lle		2mos.1'idas	rs	Daltin	ore	ث) <u> </u>		
d. NAME OF HOSE OR INSTITUTION	PITAL (If not in hospitol, g	ive street	oddress)		d. STREET ADDRESS				e. IS	RESIDENCE N A FARM?
Surin, fi	iold State H	(o)i	tal		0305 Fer	f d d	oad, Zone	1),	YES	NO
3. NAME OF DECEASED	Eir	1E	Middle		Last	4. DATE	Mor	nth	Day	Yeor
(Type or print)	Hichola	15	Henry		Trendel	DEATH	- Tebr	uary	0,	19 60
S SEX	6. COLOR OR RACE	7 MAR	RIED DNEVER MARRIED	☐ B.	DATE OF BIRTH		9 AGE (In years		1 YEAR IF UI	
Malo	Thi te	WIDOW	TED DIVORCED		3 אבני ושנקני	. 1897	lost birthdoyl 53 yrs.		Doys Hou	urs Mie
10a. USUAL OCCUPA	TION (Give kind of work	done 10b.	KIND OF BUSINESS OR	INDUSTR	Y 11 BIRTHPLACE (Sto	te or foreign (12. CIT:	ZEN OF WHA	AT COUNTRY
Balto Tr	orking life, even if retired ansit CO.	2	b=0		Laryland	đ			T- S	
13 FATHER'S NAME					14. MOTHER'S MAIDEN				- 1	
John Tre	ndel			1	Crtherin	a "In 10"	1.4			
	VER IN U. S. ARMED FOR		SOCIAL SECURITY NO	17, INFO		0 ,0.0.		lress .		
Tos -101	18 Pyrb-1.1 mm	mcvica)	273-04-9071	-	orin Tell	Hopai	tal_acor	de		
	EATH [Enter only one co	ouse per li	ine for (o), (b), and (c).]		A STATE OF THE STA					L BETWEEN
	EATH WAS CAUSED BY		lateral Lob	ar Pi	າຕາເຫດກາຳ າ				days	ND DEATH
11GAY	IMMEDIATE CAUSE (c			City and	1000 101110				1100	-
Conditions, if	new subtab \									
gove rise to	immediate (
cause (a), statin	g the <u>Under-</u>									
	- ' ('	IDITIONS	CONTRIBUTING TO DEAT	H BUT N	OT RELATED TO THETER	RMINAL DISEA	SE CONDITION G	VEN IN PAR	PE.	AS AUTOPS
	MAS UNDERLYING AND CAUSE OF DEATH	206. DES	SCRIBE HOW INJURY OC	CURRED	Enter nature of injury i	in Port I or Pa	ert it of stem 18.)	·		
20c. TIME OF INJ Hour o. m	10	While			E OF INJURY (Home, for y, street, office bldg., o		ly or lown)	(+	County)	(Stot
21 1 certify t	hat (1) (this haspita	1) atten	ded the deceased f	ram Co	tular 21 . 1	1952 to.	labruary	A. 19.	60 that (I) (we) 10
1 1			17 719 CD , and t							
220 SIGNATURE	1 1	^	1							22b. DATE SIGNE
Clone	steri del	(In	meo	M.	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS. 🔯			SIGNE
22c PHYSICIAN'S NAME (Type					22d. ADDRESS					
Traily (1) pe		1Jam			Springfi	ald Ha		ie soi	77	
230 BLR AL, CREMAT	ION, 236. DATE THEREO	OF	23c NAME OF CEMET	ERY OR			ATION (City fown,			(Stole)
BREMOVAL (Speci	(fy) 2-11-6	0	Parkwoo	d Ce	emeteru	Ba	ltimore,	Md.		
24. FUNERAL DIRECTO	0 0 1		ADDRESS		250 RE	EC'D BY REGIS	STRAR 256 REG	ISTRAR'S SI		
Leonard	1. Ruck 53	05 t	Hartord Rd		DATE	FEB 1 0 1	60 L	uma S.	Thurs	

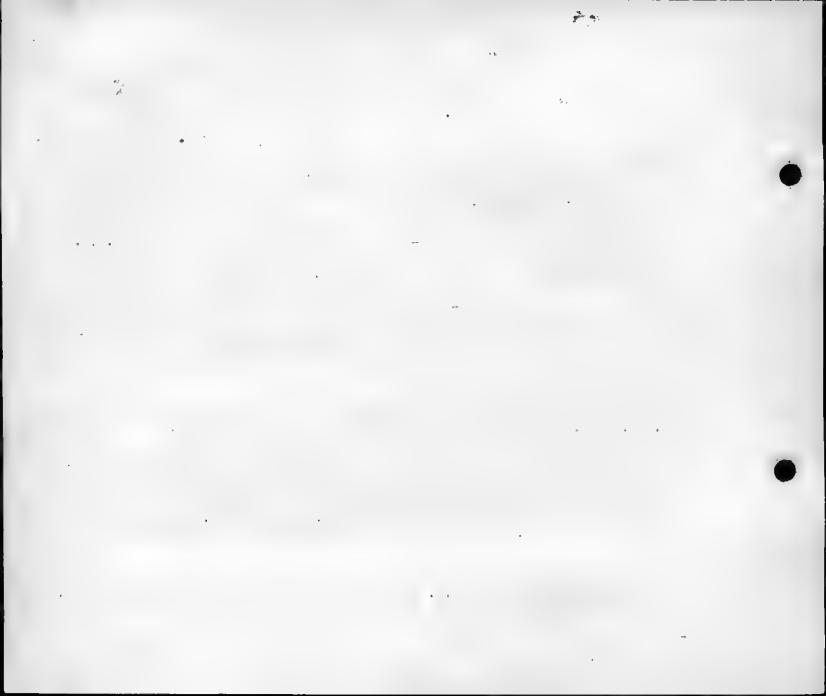


115

TO HOSPITAL OR ATTENDING PHYSIS

VR A15 (4) 15M 9/59

	2004	em 2 111116257	25-00 et		
1.	PLACE OF DEATH		2. USUAL RESIDENCE (Who	ere deceased fived. If institutions	: Residence before admission)
	o. COUNTY Carroll	MARYLAND	o STATE Mai	ryland b. county	Kont gomeny howard
	b. CITY OR TOWN (if outside corporate limits, write	c LENGTH OF STAY IN 1b	c. CITY OR TOWN (IF or	utside carporate limits, write RUR	(AL and give nearest fown)
	RURAL and give nearest town) Sykesville	7mos.24days	1.Extherence	yr/ Daisy	m's ag
	d. NAME OF HOSPITAL (If nat in hospital, give street		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
	Springfield State Hospi	tal	Asburry Met	thodist /Home/	YES NOTE
3.	NAME OF First	Middle	Last	4. DATE Month	Day Year
	(Type or print) Cora	Lavinia Stier	Brightwell	DEATH Febru	ary 18, 1960
S	SEX 6. COLOR OR RACE 7. MA	RRIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years II	FUNDER 1 YEAR IF UNDER 24 HRS
	Female White WIDOV	WED A DIVORCED	June 27, 188	31 lost birthdoy) 78 yrs.	Months Days Hours Min.
10	G USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]	b. KIND OF BUSINESS OR INDI	USTRY 11. BIRTHPLACE (Stole	or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Housewife	000	Maryland		U.S.A.
13	FATHER'S NAME		14. MOTHER'S MAIDEN N	AME	
	James 'tob Stier		Eleanora	Shipley	
15	WAS DECEASED EVER IN U.S. ARMED FORCES? 10	6. SOCIAL SECURITY NO 17	INFORMANT	Addres	\$
	(If yes, give war at dates of service)	_	Sprin, field He	ospital Records	
=	18. CAUSE OF DEATH Enter only one cause per	line for (o), (b), and (c).]			INTERVAL BETWEEN
	PART I DEATH WAS CAUSED BY:	rteriosclerotio	a cardiovacoul	nr dicence	ONSET AND DEATH
	4 -	Trentroportenous	S CALCITOVADOUL	at dracase	
	Conditions if any which \				
	gove rise to immediate				
	couse (a), storing the under				
2	7 (4)	S CONTRIBUTING TO DEATH BL	IT NOT RELATED TO THE TERMI	NAL DISEASE CONDIT ON GIVEN	N IN PART I(a) 19 WAS AUTOPSY
CERTIFICATION	C.B.S.assoc.with seni	le brain diseas	se with psycho	tic reaction.	PERFORMED? YES NO T
I SEC	20a. ACCIDENT WAS UNDERLYING [20b DI	ESCRIBE HOW INJURY OCCURR	ED, (Enter nature of injury in F	Part I or Part 11 of Item 18)	
ČE E	20g. ACCIDENT WAS UNDERLYING [20b DI OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
ĕ	20c TIME OF INJURY Month, Day, Year 20d	INJURY OCCURRED 20e. P	LACE OF INJURY (Home, form	, 20f. (City or town)	(County) (State)
MEDICAL	Haur e. m. Whi. al w	le Not while	octory, street, office bldg., etc.)	
1	21 I certify that (I) (this haspital) atter	124	June 21 10	KO Toh 78	1060 shares and
	21 I certify that (I) (this haspital) affect	R 10 60	····································	PM. AL ALAMAN	on the date stated above
	saw the deceased alive an TCb. 1	and that	death occurred are	MALIFOR THE causes and	22b DATE
ш	Clariting del a	nacho	M D PHYS DI	STAFF RECTOR PHYS	2/18/50 SIGNED
	22c PHYS CIAN'S	arrepo	22d ADDRESS	RECION L. THIS LA	2/1/1/10
r	Me (Type) Agustin delCar	moo, M.D.	Springfield	d Hospital, Syk	esville. Md.
2	a BURIAL, CREMATION, 236. DATE THEREOF	23c -NAME OF CEMETERY		23d. LOGATION (City, town, or	
	REMOVAL (Spec fy)	P	Dinner Chamilton	Hame O	(brick .
2	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS I	250 PEC'I	BY REGISTRAR 25b REGIST	RAR'S SIGNATURE
1		C 6. D. C 9	_ Need DATE FE		
	()	I would thill and were	T. TTELL DATE	-U & 3 OV	1 - 9 45



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If Institution, Regidence before admission PLACE OF DEATH o. COUNTY O. STATE b. COUNTY MARYLAND b. CITY OF TOWN IN corporate limits, write BURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION He not in hospital, give street address) AL STREET ADDRESS RESIDENCE ON A FARM? YES NO 14 NAME OF Middle 4. Day Year DECEASED DEATH (Type or print) 19 66 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS Months Days Hours WIDOWED [7] DIVORCED [7] YES. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during ment of working life even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 2 ct 2 13. FATHER'S MAME 14. MOTHER'S MALDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) INCERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse DUE TO (a), stolling the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM MALDISEASE CONDITION GIVEN IN PART 1(9) 19, WAS AUTOPS PERFORMED? 0 YES | NO 200. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 1) of item 18.) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year i 20f. (City or fown) (County) (Stote) factory, street, office bldg., etc.) Hour o. m. While Not while at work of work p. m. 21. I certify that I taok charge of the remains described above, held an Autopsy Inspection 1 Inquiry A and find that orworded to the Chief FUNERAL DIRECTOR: death resulted fram: Natural causes N Accident Suicide | | Hamicide | | Undetermined cause . DATE SIGNED **ACTUAL** CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER [7] DEPUTY MEDICAL EXAMINER 17 NAME (Type) 220. BURIAL CREMATION, 225. DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d. LOCATION (City, lown, or county) (Stote) MOVAL (Specify) 0 EUNERAL DIRECTOR'S SIGNATORE 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) DATE FFR 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

in the street of Almenille C. E. P. M. A. A. A. M. Malle " " in the state of the same of the Arting of the fact of the second 214 "1- My 12" "15" "15" " " 1512 . . .

VR A15 {4} 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1200

CERTIFICATE OF DEATH

01797

				TT									
1, PLACE OF DEATH o. COUNTY	O13		MARY	TAND	o. STATE	,		d lived. If in b. CO		: Residence	e before o	admissi	on]
1 CITY OF TOUR	Carroll	tatan I				'enne			-Te- Dist	041		A A	16 ²
RURAL and give n			E. LENGTH OF STAY	1	c CITY OR T	,	,	rore limits, w	rine KUI	(VIT oug B	As usdiez	st town	,
RuralS			2 weeks	3		lkir	ıs						
CAR INICTITUT ON	Age Nurs	-		,	d. STREET AI	DDRESS					1	ON A	PARM?
3 NAME OF DECEASED (Type or print)	TDA	irst	S. Middle		RGILL Lost		4. DATE OF DEATH		Month		6. Day		60 60
5 SEX	16 COLOR OR RACI	E 7. MARRIE	D X NEVER MARRI	ED 🗀 🛭 B	DATE OF BIRTH	1		9. AGE (In		FUNDER	YEAR IF		
Female	White	WIDOWED	DIVORCE	D []	Feb. 3,	187	72	lost birth 88	yrs			lours	Min.
10a. USUAL OCCUPATION during most of wor	ON (Give kind of world king life, even if retire	ed)		OR INDUST	RY 11. BIRTHPL	ACE (Stote	or foreign o	ountry)			EN OF W		OUNTRY
Housew:	lfe	Do	mestic		Bator	1 Rou	ige,	La.		U.	S.A		
13. FATHER'S NAME					14. MOTHER'S	MAIDEN N	IAME						
Jacob La	andry				Sina	th V	Villi	ama					
15 WAS DECEASED EVE	R IN U. S. ARMED FO		OCIAL SECURITY NO	17, IN	ORMANT				Addre	15			
(142, 10, 01 anniown)	in his distribution against			- Mrs	. Ida.	Web	er, E	Ellico	ott	Cit	y, M	[d. •	
18. CAUSE OF DEA	ATH [Enter only one	couse per line	for (o), (b), and (c).]			7				INTERY	AL BE	TWEEN
PART I. DEA	TH WAS CAUSED BY IMMEDIATE CAUSE	(0)	coan	2an	24/0	Ta	tre	240	27			ساسىر	
420.1	DUE 1		D i	, -	A C			d					
Conditions, if a	ny, which)	(b) (EAPANA.	W X	Ferry	C SOPPARA	- Le	17 7	1	4/1			
gove rise to i	mmediate (11	0 "	An mice mi		7	/	. 4				
lying couse lost.	the under-	(c)	Muni	N. B.	Ledde		المستام المستق	1 2 2	and the same				
PART II. OTI	IER SIGNIFICANT CO	NDITIONS CO	NTRIBUTING TO DE	ATH BUT I	NOT RELATED TO	THETERM	NAL DISEAS	E CONDITIO	N GIVE	N IN PART	1(0) 19.	WAS A	AUTOPSY RMED?
PART II. OTI													NO X
20a. ACCIDENT W.	CAUSE OF DEAT	н	IBE HOW INJURY O	CCURRED	(Enter nature of	injury in	Port I or Por	rt II of item 1	8)				
	MEDICAL EXAMINER	11		loo ni i	or or halling a	-	005 (5)						
20c. TIME OF INJUI	Y Month, Doy, 1	White	URY OCCURRED Not while		CE OF INJURY (I ory, street, office			y or town)		l.C.	ounty)		(\$tote
p. m.	19		at work			9	-	0	7	Al	4		
21 1 certify the	at (I) (this haspi	all aftende	d the deceased	fram _	Jel- 8	2 19	65 ta_	Yes	69	- 194	? Chat	(1) (we) las
saw-the decea	sed alive an	42	- 19 /e Wand	that de	eath accurred	09/1	M, from	the cause	es and	on the	date s	toted	abave
220 SIGMATURE	201 31	1.11			A WY CARDIAL			-T+FF				221	SIGNE
14. 500	4///	M. Ar	vital	- N	LD PHYS.	X M	ED. RECTOR	STAFF PHYS.	J		Feb	. 7	7, 8
22c PHYSICIAN'S NAME (Type)	Mi H	47	17	141	22d. ADDRE	SS							
23a BURIAL CREMAT C	N. 23b. DATE THER	EOF	23c NAME OF CEM	ETERY OR	CREMATORY		23d LOCA	TION (City,	lown, or	county)		(Stot	e}
REMOVAL (Specify		1960	Ebenezer		meterv			roll	Co.		Mary	,	
24. FUNERAL DIRECTOR	'S SIGNATURE	, = , = ,	ADDRESS			25a. REC'	D BY REGIS	TRAR 25b	REGIST	RAR'S SIG			
C.M. Wal	tz. W	infiel	ld. Mary	land		DATE !	FEB 1 0	'60	a	ritur 1	8 Han	. 4	



VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STAT

1809

ISTICAL RESEARCH AND RECOR	DS BALTIMORE 1, MARYLAND	(11798
CERTIFICATE OF	DEATH	() or 2 o

1	1. PLACE OF DEATH o. COUNTY			2. USUAL RESIDENCE (W	here deceased lived. If institution	on- Residence before admission)
	Carroll		MARYLAND	Marv	land b. county	Baltimore -
	b. CITY OR TOWN (If outside corporat RURAL and give nearest town)	,	LENGTH OF STAY IN 16		outside corporate limits, write RI	URAL and give nearest town)
	Sykesville	stol give street or	mos.19days	Baldwin d. STREET ADDRESS	<i>p</i> .	e. IS RESIDENCE
_	d NAME OF HOSPITAL (If not in hosp OR INSTITUTION					ON A FARM?
1	Springfield State	<u>Hospita</u>	1	None		YES NO TO
	3. NAME OF DECEASED	First	Middle	Last	4. DATE Mon	th Day Yeor
	(Type or print) Willi	iam	Elihu	Carlton	DEATH Febru	pary 4, 1960
	5 SEX 6. COLOR OR R	ACE 7. MARRIE	D NEVER MARRIED	8 DATE OF BIRTH	9. AGE (In years lost birthdoy)	IF UNDER 1 YEAR IF UNDER 24 HRS
	Male White	WIDOWED		October 25,	1881 78 yrs	Months Days Hours Min,
	10a USUAL OCCUPATION (Give kind of a during most of working life, even if n	work done 10b. Ki etired)	IND OF BUSINESS OR IND	USTRY 11, BIRTHPLACE (Stoke	ar foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Carpenter	Bu	ilding	North C	arolina	U.S.A.
	13. FATHER'S NAME		0	14. MOTHER'S MAIDEN	NAME	
	John Carlton			Camelia	Green	
	15 WAS DECEASED EVER IN U. S. ARMED		OCIAL SECURITY NO 17.	INFORMANT	Addr	ress
	(Yes, no, or unknown) (If yes, give wor or do		L9-03-2556	Springfield H	ospital Records	
	18. CAUSE OF DEATH [Enter only of			A 1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	OUDE OUT TO OUT TO	INTERVAL RETWEEN
	PART I, DEATH WAS CAUSED IMMEDIATE CAL	*		c heart disea.	94.	ONSET AND DEATH
	1 1 7 0 0		7C1 100 G1G1 0 01	0 11001 0 01000		1 2002 0
	Canditions, if any, which)	JE TO Cor	onary arteri	osclerosis		Years
	gave rise to immediate	(b)		myocardial in	forct in left	Months &
	lying cause last.		entricle wall	MACCALGIAT TH	rarco m rero	vears
				IT NOT PELATED TO THE TERM	HNAL DISEASE CONDITION GIV	
	g C.B.S.assoc.with	cerebra	l arteriosclo	rosis with ps	ychotic reaction	PART 1(a) 19. WAS AUTOPSY PERFORMED?
	T 200 ACCIDENT WAS UNDERLYING	T 205 DESCR	ISS HOW INTURY OCCUR	RED. (Enter noture of injury in	Part I as Part II of Item 18.1	TEME! NO [
	C.B.S. assoc. With C.B.S. assoc. With 200 Accident was underlying in contributing in cause of di	EATH NERT	THE HOTE INJOKE OCCOR	CED. (ERIER ROTOTE OF TRIOTY IN	101110110111011101110111011	
	1		URY OCCURRED 20e	PLACE OF INJURY (Home, for	m, 20f (City or town)	(County) (State)
	20c TIME OF INJURY Month, Doy Hour o. m.	While	Nat while	octory, street, office bldg., et	c.)	(County) (sidile)
		19 of work				
						L ₂ , 1950_, that (I) (we) last
	saw the deceased alive an.	<u>Teb. 3, </u>	19.60 , and that	death accurred at 31.	3M, Abm the causes an	d an the date stated above.
	22a SIGNATURE	11-	1	ATTENDING		22b DATE SIGNED
	7lles~	X M	arg Mun	M.D PHYS	AED. STAFF PHYS 🗷	2/4/60
	22c PHYSICIAN'S NAME (Type)		1	22d. ADDRESS		
	Ellis	S. Marge	olan, M.D.	Springfi	eld Hospital, S	ykesville, Md.
	23a. BURIAL, CREMATION, 23b. DATE TH	HEREOF	23c NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, fown,	of county) (Stole) /
	BREMOVAL (Specify) Feb (6-60	12/2/20	10 Radeds Bul	Test Boyd	win my
	24. FUNERAL DIRECTOR'S SIGNATURE	11/11	ADDRESS	250/REC		STRAR'S SIGNATURE
	11702 111 4	CM2/2	dartillas	LE MED, DATE F.	EB 8 '60 C.	Must & France
1		1	/			



N

01

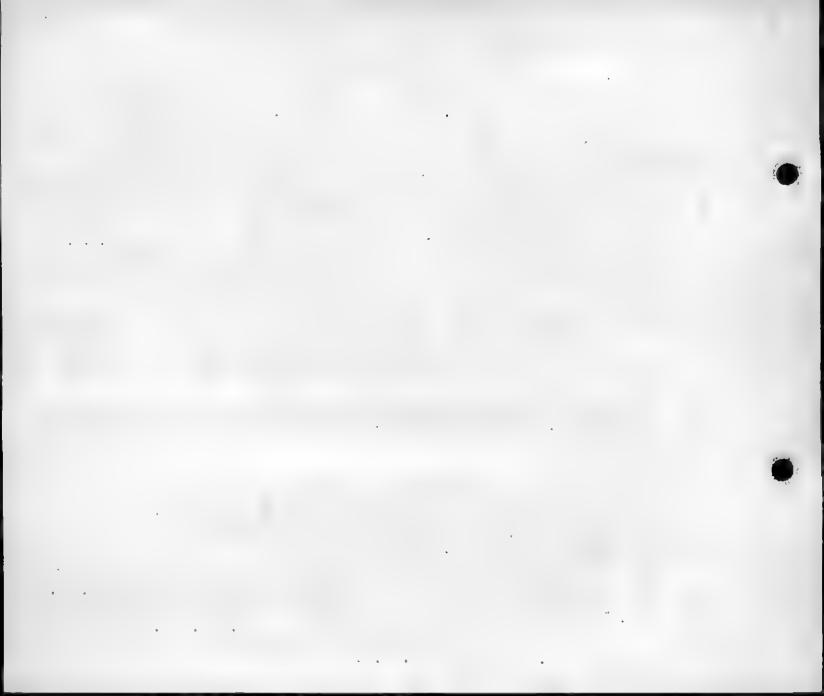
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01799

			.7.	RIO	CER	TIFICA	TE OF D	EATH						
	1 !	LACE OF DEATH		910				IDENCE (W	here decease	d lived. If institution	on. Residence	e befar	e odmiss	ion)
	٥	Carroll			N	LARYLAND	a STATE Mary	land		b. COUNTY	Montg	ome	гу	×
	b	CITY OR TOWN (IF	outside corporate lim	ıts, write	c LENGTH OF S	TAY IN 15	c CITY OF	TOWN (If	outside corpo	rate limits, write R	URAL and gr	Ye neo	rest town	1)
		Sykesvi			7 mo. 7	dava	Tako	ma Pa	rk		* a d*-d			
	c	NAME OF HOSPITA	L (If not in hospital, g	give street a			d. STREET						IS RES	IDENCE FARM?
51			eld State	Hospi	tal		403 0	laybo	urne A	venue				NO 🔽
	3 P	NAME OF	Fi		#1per	iddle		ıst	4. DATE	Mon	th	Day	Day Year	
		Type or print)	Ma	ľV	El	len Ca	hill Ca	sev	DEATH	Februar	y	1		1960
	5 S	EX	6 COLOR OR RACE		ED NEVER MA		B DATE OF BIR		1	9. AGE (In years	IF UNDER T			7
	1	Female	white	WIDOWE	DIVO	ORCED 🔲	August	21.	1863	last birthday) 96 yrs.	Months	Days	Hours	Min
	100.	USUAL OCCUPATION	(Give kind of work	dane 10b K	IND OF BUSINE	SS OR INDU	STRY 11. BIRTH	LACE (Stole	e ar fareign c		12 CITIZ	EN OF	WHATC	OUNTRY
		during most of working Housew:		1]	-		Ne	w Yor	·lc			U.S	. A.	
	13.	FATHER'S NAME					14 MOTHER						-	
		Michael	Cohill				Jos	enhin	e Ryan					
	15.	WAS DECEASED EVER	IN U S ARMED FOR	RCES7 16. S	OCIAL SECURITY	(NO 17 H	HORMANT	Opera	10 10 01	Add	ress			
	{Yes	no, or unknown) (II	yes, give wor or doles of :		None		Springfi	eld H	ospita	l record	5			
		18. CAUSE OF DEAT	H [Enter only one co				· F					INTE	RVAL BE	TWEEN
		PART 1 DEAT	H WAS CAUSED BY		lateral		mie						ET AND	DEATH
		1. 1	IMMEDIATE CAUSE (d DUE TO		Tanerar	priocent	ALLECT			·		-	~ <u>7</u> U	
		Canditions, if an	htab V	-	terioscl	eretic	o ordic	17 0 Q C 13	ler di	92292		v	ears	1
		gave rise to im	mediate (OGI TOBOL	GIOGIC	Carage	10,000	442 42	500.50				
		cause (o), stating the lying cause lost	ne under-	ol .										
	Z		R SIGNIFICANT CON	ND TIONS C	ONTRIBUTING TO	DEATH BUT	NOT RELATED	O THE TERM	MINAL DISEAS	E ÇONDITION GIV	EN IN PART	1(a) 1	WAS.	AUTOPSY
· And	ICATION	C.B.S.	assoc. Wi	th ce	rebral a	rteri	oscleros	is wi	th psy	chotic r	eactic	n	YES [NO 🔀
	LIFIC	20a ACCIDENT WAS	UNDERLYING	20b. DESC	RIBE HOW INJU	RY OCCURRE	D. (Enter nature	of injury in	Part 1 or Par	rt II of item 18.)		1		
	CERTIF	OR CONTRIBUTING	☐ CAUSE OF DEATH MEDICAL EXAMINER)											
	S	20c. TIME OF INJURY	Month, Doy, Ye	or 20d, IN	JURY OCCURRED		ACE OF INJURY			y or town)	(C	ounty)		(State
	MEDICAL	Hour o.m.	19	While of work	Not while	7 10	ctory, street, off	ce bldg., et	rc.)					
	~	21 I certify that	distable benefits				June 2	14	050 A-TI	ebruary	1 1060) 16	mt /13 /	way las
		sow the decease								the couses or				
		22a S GNATURE	d dive on gg	1	17.00	ona mor c	- CCUIT	ed ur Oe	۱۹۱۹ و ۱۹۹۹ م ۱۹۹۳مبر ۱	The couses on	ia un ine	dule		ь рате
		Za	(home of	The	willes	ice.	ATTENDI	NG T	MED DIRECTOR	STAFF PHYS			2/1	SIGNED 1
		22c PHYSICIAN'S	7				22d. ADD						P=_{=do.	/ 00
		NAME (Type)	Edmund Lus	sthaus	, M.D.		Spr	lngfie	ald Hos	spital, S	ykesvi	llle	, Mo	i.
	23a	BURIAL, CREMATION	i, 23b DATE THERE	OF	23c. NAME OF	CEMETERY C	R CREMATORY		23d LOCA	TION (City, town,	or county)		(Stat	te]
		REMOVAL (Specify)	2/4/60				Cemet	שיין פ		Geo. Co		ry	-	_
	24	FUNERAL DIRECTOR'S	SIGNATURE		ADDRESS	Wash			C'D BY REGIS		STRAR'S SIG			
	ľh	e S.H.Hi	nes Co.,	2901	14th S	t. N	W.	DATE !	EB 3	'60 a	relius S.	the	u.s	

TO HOSPITAL OR ATTENDING PHYSIS VR A15 (4) 15M 9/59



24a, REC'D BY REGISTRAR

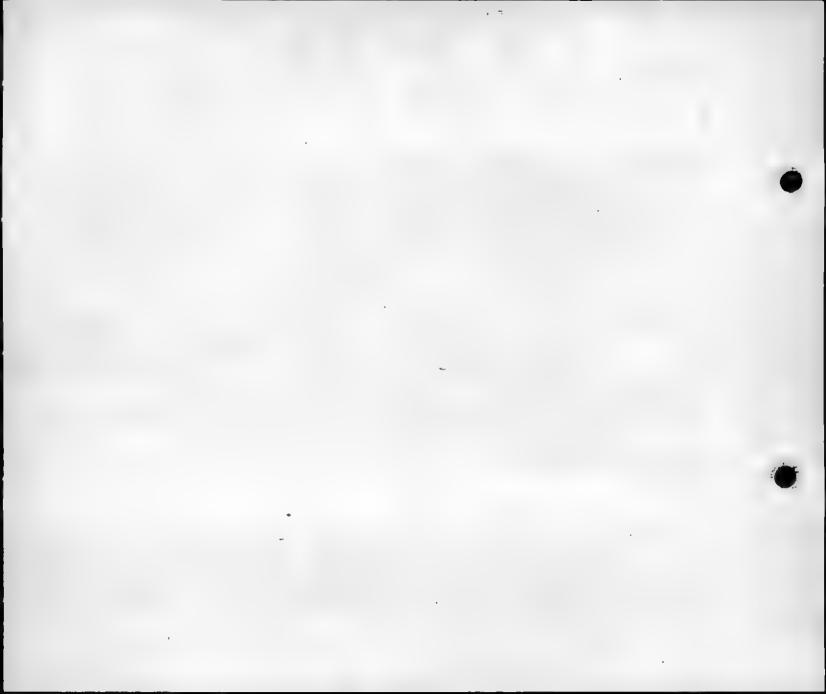
Circhar S. House

rs after deoth.

VS A1S (4)

15M **■/**55





15M 9/58





ADDRESS

01804

e. IS RESIDENCE

ON A FARME

YES NO

INTERVAL BETWEEN

PERFORMED? YES NO T

(Stote)

(County)

24b. REGISTRAR'S SIGNATURE

(Thur S. Flence

24g, REC'D BY REGISTRAR

(Stote)

Year

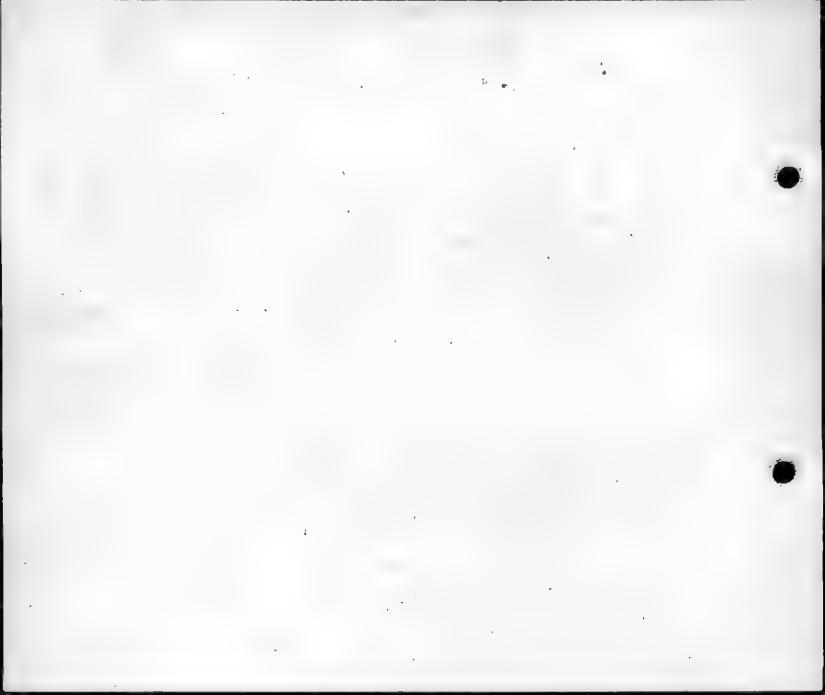
196

that the death certificate be VS A15 (4)

0

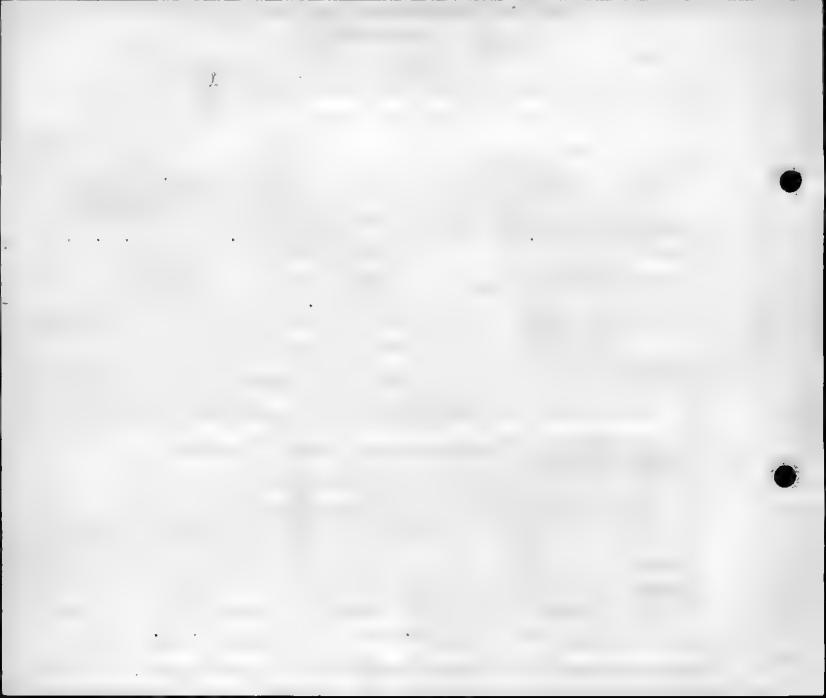
15M 9/5B

NERAL DIRECTOR'S SIGNATURE



nours ofter death. Page

requires that the death



VR ATS (4) TSM 9/59

		-/-/\dagger-10\d
j	1. PLACE OF DEATH a COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY (CARCELL)
	b CITY OR TOWN (if autis'de corporate limits, write RURAL and give neares/Jawn) AULIA NAME OF HOSPITAL (What in haspital, give street address) OR INSTITUTION Private home	c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) **Haulal - Chaptelse Tille d STREET ADDRESS e. 15 RESIDENCE ON A FARM? YES NO
	3 NAME OF DECEASED (Type or print) FANNIE ARDEEN	DUVALU DEATH HILL 16 1960
	S. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED WIDOWED DIVORCED DIVORCED	8. DATE OF BIRTH April 27 1875 9 AGE (In years lost birthday)
	100 USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDL during most of working the even if retired)	md. U.S.A.
_	AS FATHER'S NAME WILLIAM MORPHELL	14. MOTHER'S MAIDEN NAME Saker
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. I	12) alfred Finites - chapterville, mel.
	DUE TO Canditions, if any, which) IB CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Canditions, if any, which) (b) HMURI LEUX	Lemorehage. Interval between onset and peath sudden
	gave rise to immediate cause (a), stating the under lying cause last. DUE TO generalized	Of ferio Sclesson yours T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS
<u></u>	Chr. Heart failur	PERFORMED? YES NO
		ED. (Enter nature of injury in Part I ar Part II of item 18.)
	20c TIME OF INJURY Manth, Day, Year 20d, INJURY OCCURRED 40e. Plant a.m. 41 work at wark at wa	LACE OF INJURY (Hame, form, ¹ 20f (City or town) (County) (Statestry, street, affice bldg., etc.)
	21 I certify that (I) (this hospital) attended the deceosed from Aug 27, 1957, to Fele: 16, 1962, that (I) (we) to saw the deceosed alive on 1960, and that death occurred of AM, from the causes and on the date stated above	
	220 SIGNATURE Same Olevetman	MD PHYS DIRECTOR DISTAFF PHYS DIRECTOR
	22c. PHYS CIAN'S Sani Okutman	22d ADDRESS Sylkesville, Hd.
	230 BJRIA., CREMAT ON 23b, DATE THEREOF 23c, NAME OF CEMETERY OF BUSILEY 2-19-60 MONTESTALL	y Chapel near Damascus, Md,
	La FUNERAL DIRECTOR'S S GNATURE.	250 REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE DATEFEB 2 3 '60
	be the second se	- AL - CEALUR-



VS A15 (4) 15M 9/\$\$

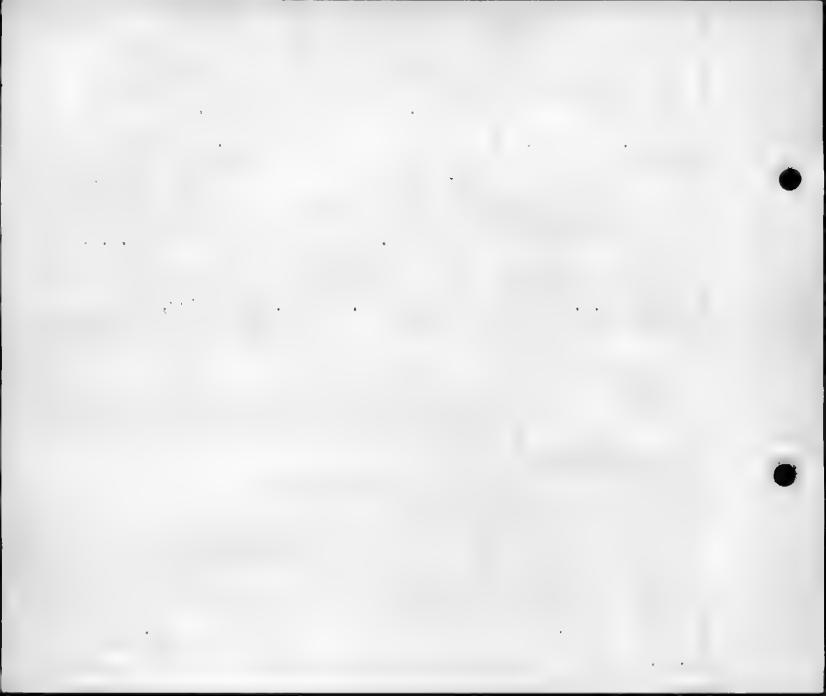
	м	
	-	
	4	
- 10	71	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1799 CERTIFICATE OF DEATH

Reg. Dist. No.

	1. PLACE OF DEATH a. COUNTY						HINCE (Wh	ere deceased lived.		Residence	before adm	ission)
		rroll		. A	MARYLAND	o. State Mar	ylan	.đ	. COUNTY	Carro	11	
		f outside corporate lim	its, write	c. LENGTH OF	STAY IN 16	c. CITY OR T	OWN (IF o	utside corporate lin	nits, write RUR	AL ond give	e nearest to	wn)
	Westminst			9 yr	s.	West	mins	ter. Md				
		AL (If not in hospital,	give street c	address)		, d. STREET A	DDRESS				e IS R	ESIDENCE A FARM?
		Main. St				169 W.	Mai	n, St.				NO A
	3. NAME OF		rst	M	iddle	las		4. DATE	Month		Day	Year
	(Type or print)	CLIFFORD		v.	ESW	ORTHY		DEATHE OD	ruary		1,	1960
	S. SEX	6. COLOR OR RACE	7. MARRI	IED 🚰 NEVER M		8. DATE OF BIRTH			1 1 1 1		EAR IF UN	
1	Male	White	WIDOWE	D DIVO	ORCED 🔲	Februar	y 10	,1914	45 yrs	nonini De	ys Hour	Min.
j	10o, USUAL OCCUPATIO	ON (Give kind of work	done 10b. I	KIND OF BUSINE	SS OR INDU	STRY 11. BIRTHPL	ACE (Stole	or foreign country)		12. CITIZE	N OF WH	AT COUNTRY
	Route Sal			arroll	Dist.	Mary	rland			U.S	3.A.	
	13. FATHER'S NAME					14. MOTHER'S	MAIDEN N	IAME				
	James H	oward E	swort	thv		Mare	aret	Helen	Blac	ck		
	15. WAS DECEASED EVE	R IN U. S. ARMED FO		SOCIAL SECURITY	Y NO. 17, I	NFORMANT	,		Address	1		
	Yes	W.W. 11	2]	15-26-1	.503 M	rs. Ell	a M.	Mc Cor	mick,	Se	me	
		TH [Enter only one c	ouse per lin	e for (o), (b), and	d (c).]	6		(INTERVAL	
	PART I, DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (s	-	showing .	ez ac	ciu	per comple				unt-
	440,1	DUE TO	,	2		1					,	
	Conditions, if o		b) (2	-6-4-E-	James	deries	1 6	CLERK	12.1		6%	ko +
	gove rise to i		;		1		r					
	lying cause lost.		c)									
	PART IL OTE	IER SIGNIFICANT CO	IDITIONS C	ONTRIBUTING TO	O DEATH BUT	NOT RELATED TO	THE TERMI	NAL DISEASE CON	DITION GIVEN	IN PART 1	(o) 19. WA	S AUTOPSY
1	l S] NO [2]
	PART II. OTH	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b, DESC	CRIBE HOW INJU	RY OCCURRE	D. (Enter nature of	f injury in I	ort I or Part II of i	tem 18.)			A
	(IF EITHER, NOTIFY	MEDICAL EXAMINER)										
	20c. TIME OF INJUR	Y Month, Day, Ye	ar 20d. IN	JURY OCCURRED	D 20e. PL	ACE OF INJURY	iome, farm	20f. (City or tov	vn)	{Cou	infy)	(State)
	20c. TIME OF INJUR	19	While of work	Not while	ר וי	ctory, street, office	blog., etc.	1				
	-	at I attended the			-17-	1957	to 4	21 1	10/2	Sheet I do		
	olive on	The state of the	19 *				477	-31	1942-01			
	drive on	7		CA and	rnar dearr	accurred at		ZM, fram the			date sta	ited abaye Date signe
	ACTUAL	tauce -	7	D Manne	4	/	05	ユニ ケソノ	466 64		21	1/100
f	SIGNATURE	200000		1	, , ,	M.D					/_	1 Care
	PHYSICIAN'S NAME (Type)	AMES	TI	MARS	H			1 Protect	يديدن			Mi
	220 BURIAL CREMATIO	N, 226. DATE THERE	OF .	22c. NAME OF	CEMETERY C	R CREMATORY		22d. LOCATION (City, town, or	county)	(St	ale)
	Burial (Specify)	Feb.4,	1960	Locust	Grov	e Cemet	ery	Frederi	ck, Co		Mary	land
	23 FUNERAL DIRECTOR	S SIGNATURE		ADDRESS					24b. REGISTR		1/	
	C. M. We	1tz	Win	etala.	Billio marell	3	DATE FE	B 4 '60	61.7		-	



1817 CERTIFICATE OF DEATH

haurs ofter death. Page 4

may be retained by the haspital or settificate him been signed by the attending physician and completely filled in by the funeral director.

The NUNERAL DIFECTOR: After this contricts him been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be director to burio, cremation, ar removal, and in ony event within 72 haurs after death.

The law requires that the death certificate be executed with

TO HOSPITAL OR ATTENDING PHY

VS A15 (4) 15M 9/5B Red Dist No.

									Keg. Disi	. 140.				
1. PLAC o. CC	e of DEATH SUNTY Car	roll		MARYLA	ND	2. USUAL RESIDENCE (Who. STATE Maryla		d lived. If institution b. COUNTY	on: Residence	e before o	dmission)			
b. CI	TY OR TOWN (If RAL ond give nec	outside corporate limits,	write c. LEI	NGTH OF STAY IN	1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)								
, KO	Henry		1.0	057 days		Baltimor	е			· VOI	,4			
d. N/	AME OF HOSPITA	L (If not in hospital, give				d. STREET ADDRESS				0. 15	RESIDENCE			
	H	enryton Sta	ate Ho	spital		3447 Che	ssel	Court			S NO			
3. NAM DECE (Type	E OF ASED or print)	First Arth	ur	Middle Lee		Faison	4. DATE OF DEATH	Mon Februar		Day	Year 19 60			
5. SEX		6. COLOR OR RACE 7	MARRIED 🔼	NEVER MARRIED	□ TB	DATE OF BIRTH		9. AGE (In years	IF UNDER 1		JNDER 24 HRS			
Ma	le		IDOWED []	DIVORCED	_	3-6-24		lost birthdoy) 35 yrs.	Months E	Doys Ho	ours Min.			
10a. USL	JAL OCCUPATIO	N (Give kind of work dor	le 10b. KIND	OF BUSINESS OR	INDUS1	RY 11, BIRTHPLACE (State	or foreign o		12 CITIZ	EN OF WI	AT COUNTRY			
	ng most of works None	ng life, even if retired)				Farmvil	le. N	. C.		V. S	. A.			
_	ER'S NAME		1			14. MOTHER'S MAIDEN N	-		-					
	Wi	lliam Fais	on			Unknow	n							
15. WAS	DECEASED EVER	IN U. S. ARMED FORCE	57 16. SOCIA	L SECURITY NO.	IN	FORMANT		Add	reas					
No.		f yes, give war or dates of servi	227-	26-0680		Arthur Fai	son -	Patient						
		H (Enter only one cause									AL BETWEEN			
	PART I. DEAT	H WAS CAUSED BY:		_	iscu	lar insuffi	cieno	v		ONSET	AND DEATH			
	002X	IMMEDIATE CAUSE (o) DUE TO												
- 1	nditions, if on			Cor-Puln	one	le								
go	ve rise to in	mediote (DUE TO												
	ise (a), stoting th ng couse last.	(c)_		Far adva	mce	d bilateral	pulm	onary th)C.					
Z -	PART II OTHI		IONS CONTRI	BUT NG TO DEAT	H_BUT N	IOT RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIV	EN IN PART	1(o) 19. V	VAS AUTOPSY			
3											ERFORMED? S 🔲 NO 📋			
	ACCIDENT WAS CONTRIBUTING ITHER, NOTIFY A	UNDERLYING 20 CAUSE OF DEATH MEDICAL EXAMINER)	b. DESCRIBE P	fow injury occ	URRED.	(Enter nature of injury in F	Part I or Pa	rt II of item 1B)						
WEDICAL	TIME OF INJURY Hour a. m p. m.	Month, Doy, Year		Not while	PLA(CE OF INJURY (Home, form ary, street, office bldg., etc.	, 20f. (Cit	y or town)	(Ce	ounty)	(Stole			
21.	I certify the	ot I attended the d	eceased fro	m_ March	1 20	, 1957, to Fe	bruar	y 10 ₁₉ 60	hat I los	t saw th	e deceose			
ali	ve on Fel	ruary 10	19 60	_, and that d	eoth	occurred at 4:50	A. from	the causes on	d on the	dote str	oted obov			
	4							itreet, city or town,			DATE SIGNE			
ACT SIGN	VAL AL	gars M. Ma	en lace	7 14.8.	м	.p. Henryton	, Mar	yland		2-	-10-60			
	WE (Type) D	r. E. M. Ma	culan	s, Supt.		Henryton	Stat	e Hospit	al He	nryto	on, Md			
220. BUR	HAL, CREMATION HOVAL (Specify)	Felh 13/	960 1	NAME OF CEMETE	RY OR	Cemeter,	nd LOCA	STION (City, town, of	Mi livil	m)	(State)			
23. FUNE	RAL DIRECTOR'S	SIGNATURE	4 4	ADDRESS		240. KEC'	BY REGIS	TRAR 24b. REGIS	STRAR'S SIG	NATURE				
40	us 5	Russ.	7972	W. Nori	he	aul DATE EL	en 1.5	60 0	Liver 8	thouse				

ז יָי די

-	DIAGO OF REATH
	o. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Regidence before admission) b. COUNTY b. COUNTY Count
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RURAL and give nearest lown)
	d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION OR A FAR YES NO.
	3. NAME OF DECEASED (Type or print) CLARA ARMINITA FITE DEATH OF DEATH 3. 197
	5. SEX 6. COLOR OR RACEY 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 1. SEX HEMSEL WIDOWED DIVORCED MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED NEVER MARRIED 18. DATE OF BIRTH 1. SEX HOUSE 15 MARRIED NEVER MARRIED NE
\\	10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) 12. CITIZEN OF WHAT COUNTY 19. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTY 19. BIRTHPLACE (State or foreign country)
	GRATE Waddell Mary & Harman
Ĭ	15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes, give wor or delea of vervice) (If yes, give wor or delea of vervice) (If yes, give wor or delea of vervice)
ľ	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carden failure, Carden failure, Carden failure
	420.0 DUE TO Conditions, if ony, which) (b) Access, anterwedges are Ceneralist, arihiti to
	gove rise to immediate couse (a), stoling the under-lying couse lost. DUE TO (c) Burnline framewire. 3 9 as
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUT PERFORME YES N
	20s. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Doy. Year 20d INJURY OCCURRED Hour a.m. While Not while of work of
	21. I certify that (I) (this haspital) attended the deceased fram. 1954. 19to 3 3
	220 SIGNATURE & Hall M.D ATTENDING MED STAFF 2/4/60 SI
	PHYSICIAN'S NAME (Type) HOWARD E, HALL 22d. ADDRESS Affemille: mg.
	230 BJRIA., CREMATON, 23b DATE THEREOF 23c NAME OF CENETERY OR COMMANDER 23d. (STATION (City town, or county) (State)
	24 FUNERAL DIRECTOR'S SIGNATURE 256, REGISTRAR'S SIGNATURE

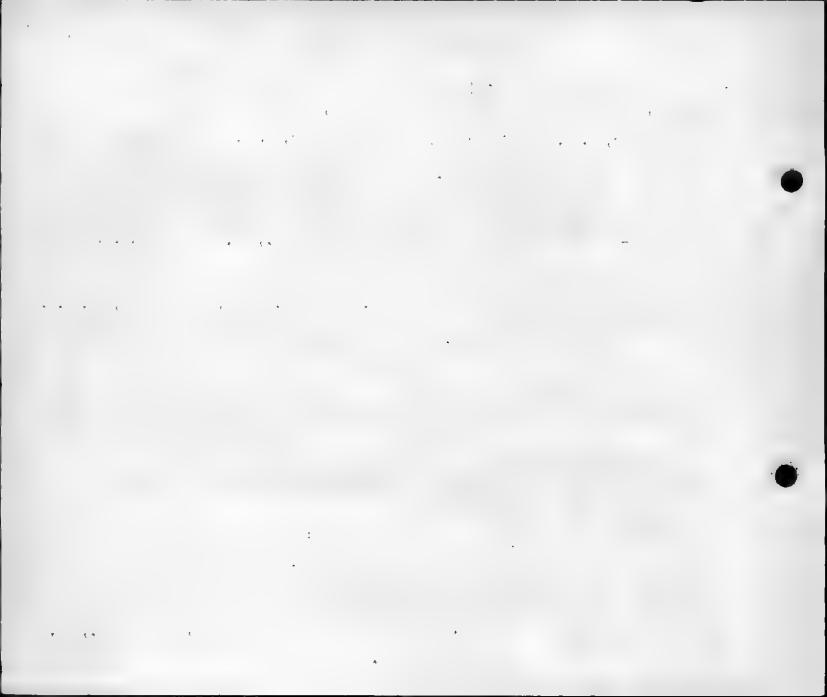
hours after death. Page 4

may be retained by the hospitol at

VR A15

DATE FEB 2 5 160

death



Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) county r. George's c CITY OR TOWN (If autside carporate timits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO Year 60 19 IF UNDER 1 YEAR IF UNDER 24 HRS. Manths 12. CITIZEN OF WHAT COUNTRY? U. S. A. INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES NO T

Beltsville Henryton d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS 5516 Odell Road Henryton State Hospital 4. DATE 3. NAME OF Middle DECEASED William Gaither DEATH Feb (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9 AGE (In years last birthday) 8. DATE OF BIRTH Male Negro 3-13-1882 WIDOWED 🕅 DIVORCED | 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11 8IRTHPLACE (State or foreign country) during most of working life, even if retired) Maryland Unknown 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (If yes, give wor or dates of service) Hospital Record - Pr. George's County. Unknown Unknown 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I, DEATH WAS CAUSED 8Y: Cardiovascular insufficiency, Assian Flu DUE TO Far advanced bilateral pulmonary Tbc. Conditions, if ony, which gove rise to immediate DUE TO couse (a), stoling the under-Diabites Mellitus lying couse last. PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) 19

MARYLAND

c. LENGTH OF STAY IN 1b

Maryland

been signed per buriol-tronsit physician ging certificate moy be retained by the TO FUNERAL DIRECTOR: poge 3 should be detach

il director

funerol

25

fifled hes 1 o

complete

puo

physici

ā

Έ

certificate

bd

pup 2.

21. I certify that I attended the deceased from Mars 17. , 19.58, to Feb. 5. , 1960, that I last saw the deceased

20c. TIME OF INJURY

Haur o.m.

CATION

MEDICAL

PLACE OF DEATH

Carroll

RURAL and give nearest tawn)

b CITY OR TOWN (If autside carporate limits, write

· COUNTY

Day. Year

200. ACCIDENT WAS UNDERLYING ACCIDENT WAS UNDERLYING ACCIDENT

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20d. INJURY OCCURRED Not while at wark at wark

1960

20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)

20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Port II of item 18)

(County) (State)

ACTUAL SIGNATURE

ADDRESS (Street, city or lown, state) Henryton, Maryland

____, and that death accurred at 6:00pM, from the causes and an the date stated above.

20f (City or town)

DATE SIGNED 2-5-60

Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.

220 BURIAL CREMATION, 226. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY. Chape/ Cem Queens

22d LOCATION (City, town, or county)

(State)

REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE

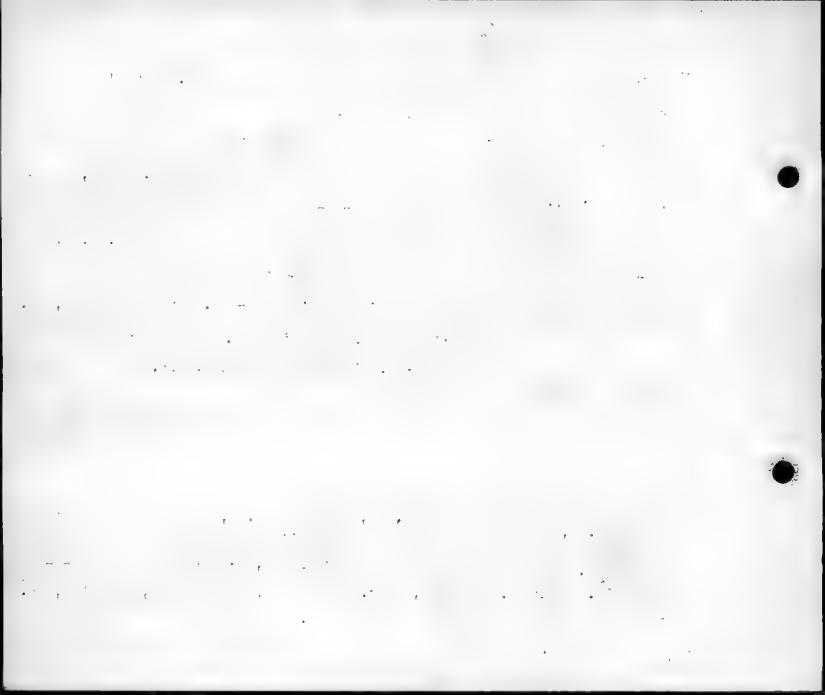
ADDRESS.

24g. REC'D BY REGISTRAR FEB 1 1 '60

Cirthur & House

VS A15 (4) 15M 9/58

prior



VR A15 (4) 15M 9/59

0

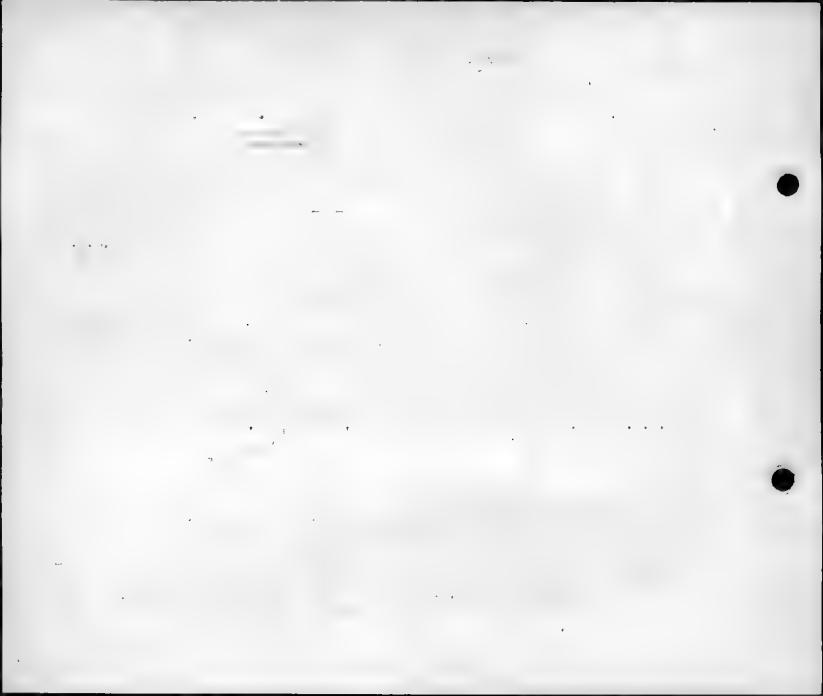
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

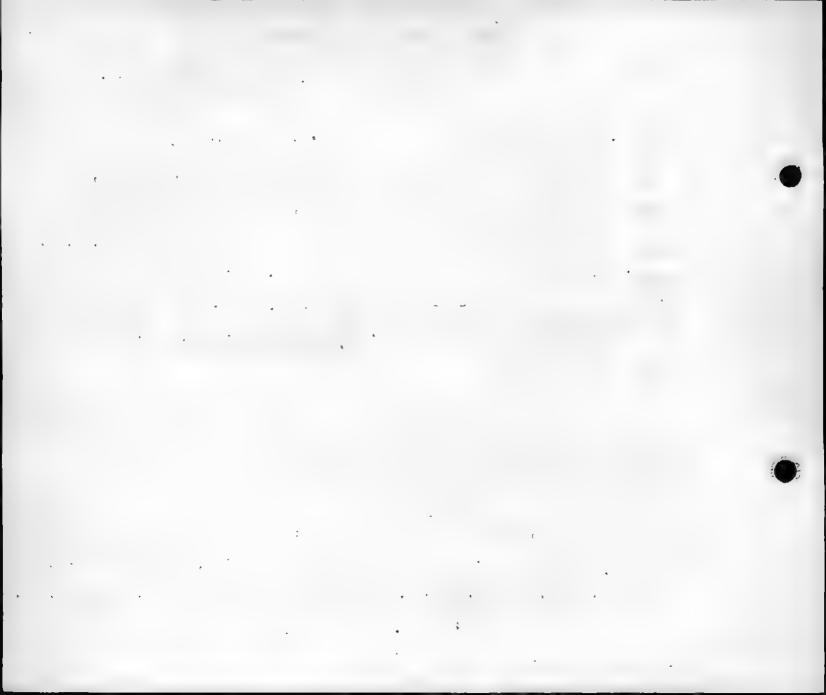
CERTIFICATE OF DEATH

- 1) I	-0	b	9
(<u> 1</u>	2	Ĵ.	4

	_	`	
- 1		1	١
14	١.		1
1 3	ij.		
34			l
		- 4	F

1.	PLACE OF DEATH	1.0	A L			2. USUAL RESIDE	NCE (Whe	re decease			n Reside	nre befor	e admiss	on)
	. COUNTY Carr	oll		MARYLA	AND	a. STATE	vil and	7	ь. С	YTAUO	C11	tv	V	P
	b. CITY OR TOWN (II	f outside corporate limits, wr	ite c. LENC	TH OF STAY IN	416	c CITY OR TO	WN (If ou	tside corpo	prote timils,	write Rt	JRAL ond	give nea	rest town	
	RURAL ond give no		2 m	8 days		Bal	ta mor	20 23	. 177.			21/4	111	1
	d. NAME OF HOSPIT	AL (If not in hospital, give st	reet address)	U Ways		d. STREET ADI	Market Add No. of Street		مناسيو.				B. IS RESI	DENCE
	OR INSTITUTION	ield Scate to	smital			1729	Garagin	TOPT.	Stree	4.			ON A	
2	NAME OF	First	DOT OUT	Middle		Last		4. DATE	00100	Monl	ds.	Da		eur eur
	DECEASED (Type or print)	James		MIGGIE		Gardine		OF DEATH		2	111	50	'	9 60
5.			4400150 🗆 6	IEVER MARRIED	1 m	B. DATE OF BIRTH			9. AGE (I		IF UNDE	R 1 YEAR	IF UNDE	
			OWED	DIVORCED		- 4 0	Ω		lost bir	rthdoy) yrs	Months	Days	Hours	Min
100	I.ale	N (Give kind of work done				3-25-8	C (State o	r foreign c	(L	715	12 CII	FIZENI OE	WHATC	OHNITRYS
100	during most of work	ing life, even if retired)	TOB. KIND OF	BUSINESS OK	IIADO2	i .	_		.commy)		12. C			OOMIKIS
	Laborer						aryla	- A B W				U.S	ell e	
13.	FATHER'S NAME	_				14. MOTHER'S N	AIDEN NA	AME						
		les Gardiner					<u>theri</u>	ine Ly	vons					
		R IN U. S. ARMED FORCES? (If yes, give wor or dotes of service)	16. SOCIAL S	SECURITY NO.	17 IN	FORMANT				Addr	ess			
	no		unk	n		Mospital	reco	ords						
	18. CAUSE OF DEA	TH [Enler only one cause p	er line for (o)	, (b), and (c).]								INTE	RVAL BET	WEEN
	PART I. DEA	TH WAS CAUSED BY:	ilater	al pulm	onar	y Tuberc	ulosi	s. fa	ar ad	vanc-	ed		ze are	
		DUE TO								I WAAY		U		
	Conditions, if a	nv. which \												
	gove rise to i	mmediole (DUE TO												
	lying couse last.	the under-												
Ž		FER SIGNIFICANT CONDITION	NS CONTRIBU	JING JO DEAT	TH BUT_	NOT RELATED TO 1	ME TERMIN	AL DISEAS	SE CONDIT	ION GIV	EN IN PA	RT 1(o) 1	9. WAS /	AUTOPSY
ATIC		FER SIGNIFICANT CONDITIONS SOC. WITH CO		arteri	OSC.	ler. with	psyc	ch. r	racti	on,			PERFO	RMED?
FIC		tent syphilis		W INHIBY OF	CHIPPER), (Enter noture of	nusy in Pr	art Lor Por	et il of Han	n 18.1			163	NO Fab
CERTIFICATION	OR CONTRIBUTING	S UNDERLYING 206 CAUSE OF DEATH MEDICAL EXAMINER)	OESCHIPE INC	/// II/30KI OC	CONNEC	, (ciner noteta di		517 1 51 151						
				country in	00- 01 A	CE OF WILLIAM AN		206 15%				(Company		(Stote)
MEDICAL	Hour o.m.	V	0d. INJUŘY O /hile Na	t while		CE OF INJURY (He tory, street, office b			y or fown)			(County)		(21016)
ME	p. m.	19 01	wark 🔲 of					į						
	21 I certify the	t (I) (this haspital) (I)	ended the	deceased f	ram	11-27-	19_	.59.ta_	2	-5	, 19_	_60 th	of (I) (we) last
	saw the deceas	sed alive an 12-	<u>5</u> →19	60, and t	that d	eath accurred	a8: I	M, fram	the cau	ises an	d an th	e date	stated	abave.
	220. SGNATURE		77										221	DATE
	Come	and He	000	Ru	a /	M.D. PHYS.	☐ MEI	D. RECTOR [STAFF.				2-	-6-60
	22c PHYSICIAN'S					22d. ADDRES	5							
	NAME (Type)	Edmund Lust	haus M	.D.		Spri	ngfie	eld S.	tate	Hosp	ital	Sy)	(esyi	lle.M
230	BURIAL, CREMATIC	N, 23b. DATE THEREOF	23c N	AME OF CEMET	TERY OI				T ON (City				(Stot	
	Burial (Spec fy)	Feb. 9,19	0.0	thedra					timo		,,		,	
24	FUNERAL DIRECTOR			DRESS			So REC'D	BY REGIS	TRAR 2	56 REGIS	STRAR'S S	IGNATUI	RE	
1	1/1/10	Afterly 1	9/3/1	1 Rat	4	n 11 -	DATE FE		60	0	T' IN 2	9 4	u A.	
5	4 12d of 1	7	7 9 00	1 Joak		THE PARTY	1 5				-(2	a, , opes		



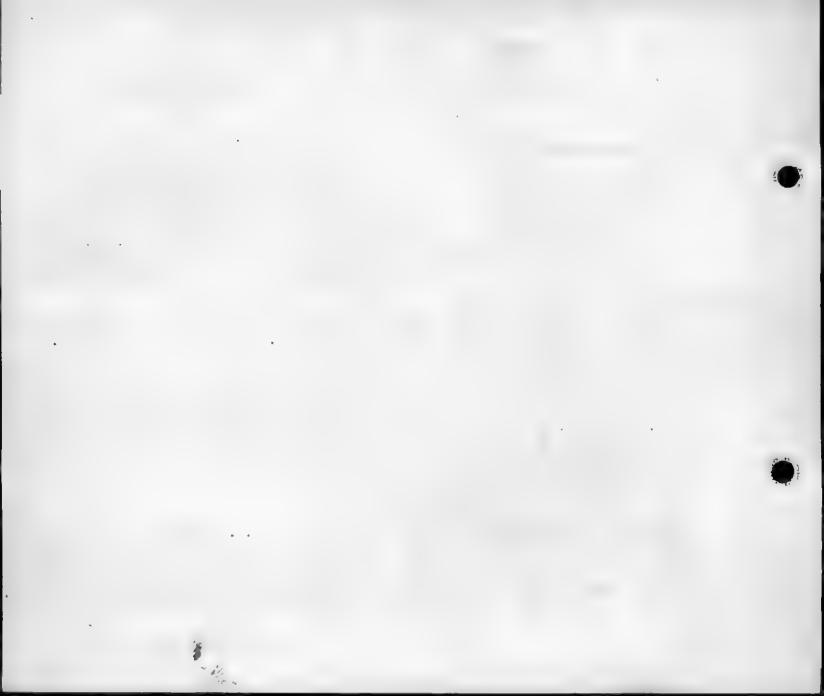


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01814

		7.0.3											
1. PLACE OF DEATH	***************************************	U 20				2. USUAL RESIDENCE (Where dec	eased	l lived. If institution b. COUNTY	on Reside	nce befor	re admiss	ion)
Carroll				MARYL	AND	Maryland				imor	e Ci	tv	
b CITY OR TOWN (I RURAL and give no	f outside carporate lim earest town)	uts, write	c. LENC	OTH OF STAY	N 15	c CITY OR TOWN (If autside o	orpo	rote limits, write R	URAL ond	give neo	rest town)
Sykesvill				10mo.2	lday	s Baltimore	9					V /	7
d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital,	give street	address)			d. STREET ADDRESS						ON A	FARM?
Springfie	1d State H	iospii	tal			610 Oldh	am St	ree	et e			YES	NO IZ
3. NAME OF DECEASED	F	rst		Middle		Last	4. DA		Man	ith	Da	У	Year
(Type or print)	Lu	igi		1010		Giordano		ATH	Februar	rv	23		1960
S SEX	6 COLOR OR RACE	7. MAR	RIED N	NEVER MARRIE		DATE OF BIRTH			9 AGE (In years lost birthdoy)	IF UNDE	RIYEAR		
Male	White	WIDOW	/ED 🔲	DIVORCED	5	October 12	, 188	3	76 yrs	Months	Days	Hours	Min
10a USUAL OCCUPATION	N (Give kind of work	done 10b	KIND OF	BUSINESS OF	NDUS	TRY 11. BIRTHPLACE (SE	ate or fare	igh co	ountry)	12. CI	TIZEN OF	WHAT	OUNTRY?
Construc	ing life, even if retire പ്പ് വാ	3)	131	21/1/1	11/3	Italy				ī	J.S.A		
13. FATHER'S NAME	0 1 011	- !	F.AC	Eilede M. Chei	-	14 MOTHER'S MAIDE	N NAME						
Unkno	wn					Unknow	n						
15. WAS DECEASED EVE			SOCIAL S	SECURITY NO.	17. IN	FORMANT			Add	ress			
No. of Unknown;	(If yes, give wer or dates of		None		Sp	ringfield H	ospit	a l	records				
	ATH Enter only one o			(b), and (c), l			VENEZ-				INTI	ERVAL BE	TWEEN
	TH WAS CAUSED BY:					hroselerosi						ET AND	
446	IMMEDIATE CAUSE (AL GC	TOTAL	пер	HOSCICIOSE	ă⊕. <u> </u>					ears	•
Conditions, if o	ny, which)	b).											
gove rise to i	mmediale (,		-									
couse (a), stating lying cause lost,	the under-												
		vDITIONS	CONTRIB	JĪING TO DEA	TH BUT	NOT RELATED TO THE TE	RMINAL DI	SEASI	E CONDITION GIV	/EN JN.PA	ART 1(o) 1	9. WAS	AUTOPSY
C.B.S.	assoc. wit	h cei	rebra	l arte	rios	NOT RELATED TO THE TE	th ps	ycl	notic rea	actio	n	PERFC	NO M
E 200 ACC DENT W	tent syphi		SCRIBE HO	W INITIRY OF	CHRRE	(Enter noture of injury	in Part Lo	r Pori	I II of item 18.)			,,,,	140 65
PART II. OTH C.B.S. Tate 1s 20g ACC DENT WAY OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER)	- 1	~,/			(Line, horote of thirty							
	Y Month, Day, Y	sar 20d.	INJURY O	CCURRED	20e. PL/	CE OF INJURY (Home, F	arm, 20f.	(City	or town)		(County)		(Stote)
Hour om	19	While	nk 🔲 at	t while	fac	lory, street, affice bldg,	etc.)						
					. 6		50	7	D . 1	03.0	40	444	
						pril 1							
	sed alive on 100	ruar,	y_ <u> </u>	94 and	that d	eath accurred at 9	- CMAL W	rióina	the causes ar	id an t	ne date		
220 SIGNATURE	t 1.1	0		6		ATTENDING	MED_		STAFF			~ /	SIGNED
22c PHYSIC ANS	upul acel	4	2726	120.		VI,D PHYS 22d ADDRESS	DIRECTO	R	PHYS X			4	23/00
NAME (Type)	del Campo		1			Springfi	eld S	ta	te Hospi	tal.	Syke	svil	le. M
23a BURIAL CREMATIC		OF 1	22- N	AME OF CEME	TEDY O				ION (City Jown,				
REMOVAL (Specify)	12.25	-60	7 Z3C. N	NEILE	10/17	Filter	230 1	1	11 / September 1	eller :	77	(Stop	-61
24, FUNERAD DIRECTOR	S SIGNATURE	1	/ AD	DORESS //	10	// 250 R	FEB 2	EGIST	RAR 25b REGI				
Midst	1. She	19/14	11	Muna	le	Talle DATE	FEB 2	9 1	bu le C	rthuy,	d. The	sud.	

hours ofter death. Page 4 may be revained by the hospital or the foundation of the contract of the foundation of campletely fulled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours ofter death. N: The low requires that the death certificate be executed with TO HOSPITAL OR ATTENDING PHYS VR ATS [4] TSM 9/59



lying couse last.

20c. TIME OF INJURY Day, Year Hour o. m.

20d. INJURY OCCURRED Not while While

20e. PLACE OF INJURY (Home, form, 20f. (City or town)

(County)

(Stote)

21. I certify that I attended the deceased from 1935

of work of work

foctory, street, affice bldg., etc.)

20 February 160 that I lost sow the deceased

____, and that death accurred at 7:30AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

22d. LOCATHEN (Crty, fawn, or county)

DATE SIGNED

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

a. COUNTY

3. NAME OF

5. SEX

DECEASED

(Type or print)

Lawson, Jr., M.D.

1960

Sykesville-2. Maryland

23	FUNE
	- /

220 BURIAL, CREMATION. REMOVAL (Specify)

RAL DIRECTOR'S SIGNATURE

22c NAME OF CEMETERY OR CREMATORY

240. REC'D BY REGISTRAR

Liberty Road at Eldersburg

245 REGISTRÁR'S SIGNATURE

O 15M 10/57

O FUNERAL DIRECTOR:
page 3 should be detac

the registror

director

the funeral shauld be for

den des

ove

after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1825 CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission g. COUNTY g, STATE **b.** COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 (c CITY OR FOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) 16 d. NAME OF HOSPITAL (If not in hospital, give fireet oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION YES NO 3 NAME OF First 4. DATE Middle Lost DECEASED OF DEATH (Type or print) 196 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX IF UNDER I YEAR IF UNDER 24 HRS AGE (In years lost birthday) Months Hours WIDOWED ID-DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME IS. WAS DECEASED EVER IN LUS. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address (Yes, no or unknown) []If yes give war or date of service] 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate **DUE TO** couse (o), stating the underlleve lying couse lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE SEMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Generalmed artisis selezasis YES 🗍 NO 🖼 20g. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. [City or town) (County) (Slote) Hour a.m. factory, street, office bldg., etc.) While Not while p. m

of work of work

NAME (Type) E.

220. SURIAL CREMATION.

REMOVAL (Specify)

21. I certify that I attended the deceased from 15 15 100 P , and that death accurred at 2 P. M. from the causes and an the date stated above.

1956, to 706 24 1960 that I last saw the deceased

ACTUAL SIGNATURE

Ambler Thomson 226, DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county)

ADDRESS (Street, city or lown, state)

(State)

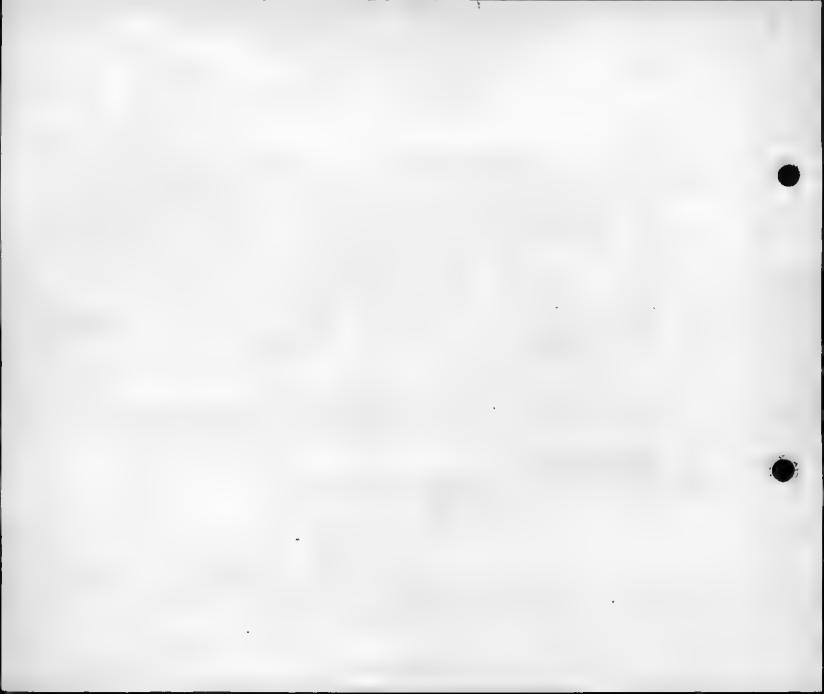
23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR DATE FEB 2 9 '60

24b. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 10/57



haurs after death. Page 4 N. The law requires that the death certificate be executed with ding physician

TO HOSPITAL OR ATTENDING PHYS!

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

b CITY OR TOWN (If outside corporate limits, write RURA RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, write RURA RURAL and give nearest town) Sylverille d. NAME OF HOSPITAL (If not in baspital, give street address) OR INSTITUTION The first Middle Loss 4. DATE Month PERK AVO.	AL and give nearest town)
d. NAME OF HOSPITAL (If not in baspital, give street address) OR INSTITUTION Constitution Consti	C. V. 1 , 100
3 NAME OF First Middle Loss 4. DATE Month	e. IS RESIDENCE ON A FARM? YES NO
DECEASED.	
(Type or print) Lathan Charles Hammond DEATH Februs	Pary 8, 1960
The state of the s	UNDER 1 YEAR IF UNDER 24 HRS Lonths Days Hours Min
100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS/OR INDUSTRY 11. BIRTHPLACE (Slote or foreign country) during most of working life, even if relired)	12. CITIZEN OF WHAT COUNTRY?
Selling chickens Harling Maryland	U.S.A.
13. FATHER'S NAME	
Nathan Hammond Alice -	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yor, no. or unknown) (If yes, give wor or drive of service)	
No Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: Pronchopneumonia	Davs
4914 DUE TO	
Canditians, if any, which)	
gove rise to immediate	
lying couse lost.	
Part II other significant conditions contributing to death but not related to the terminal disease condition given the prohosis, simple defendantion.	IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO 2
Past 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN THE DEATH OF THE TERMINAL DISEASE CONDITION GIVEN THE DISEASE CONDITION GIVEN THE DEATH OF THE TERMINAL DISEASE CONDITION GIVEN THE	
20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED Hour a. m While Not while of work of	(County) (State)
21 1 certify that (1) (this haspital) attended the deceased from Lemola 7, 1955, to Feb. 8.	. 1960 , that (1) (we) last
saw the deceased alive an = 3hruc ry 819 60, and that death occurred al : 10 Mirom the causes and a	an the date stated above
220. SIGNATURE RED. MED. STAFF DIRECTOR DIRECTOR PHYS C	22b. DATE SIGNED 2/9/60
22c PHYS CIAN'S Agustin delCampo, M.D. 22d. Adoress NAME (Type) Agustin delCampo, M.D. Springfield Hospital, Syke	7,7,00
230 BUR AL, CREMATION, 236, DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION LC by Lown, or co	(State)
24. FUNERA DIRECTOR'S SIGNATURE 250 REGISTRAR 256 REGISTRA	AR'S SIGNATURE



1827 CERTIFICATE OF DEATH

Reg. Dist. No.

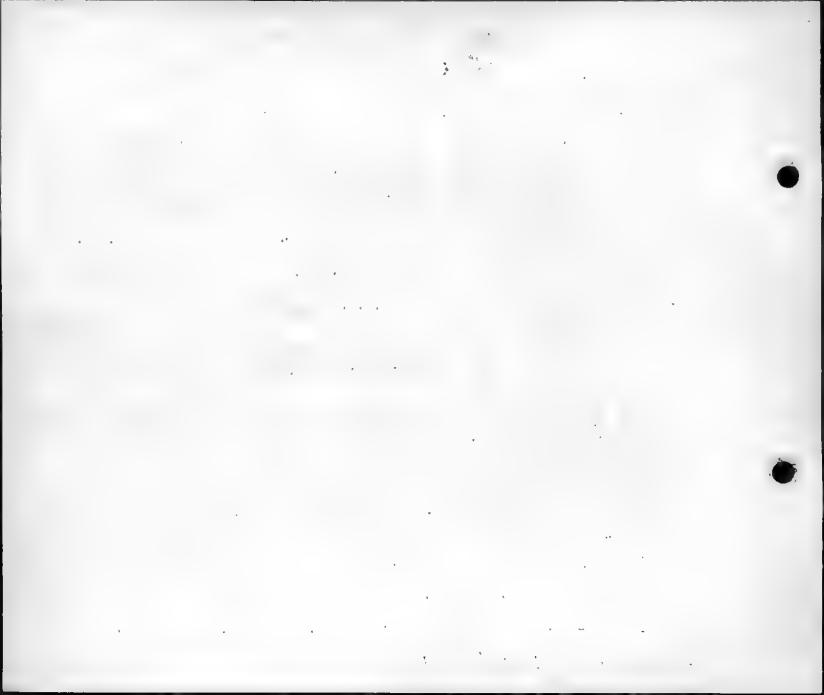
()	1	8	ĭ	۶
		hapen .	_	- 4

	1. PLACE OF DEATH o. COUNTY			I A STATE								
		Carroll	MARYLAND	ria	r yland							
	b. CITY OR TOWN RURAL and give	(If autside carporate limits, write nearest town)	c LENGTH OF STAY IN 16	c. CITY OR T	OWN (If outside corp	porote limits, write R	URAL and gi	ve nearest tow	in)			
		Sykesville	8mos 18days			<u>, Maryland</u>	1					
p-1	d. NAME OF HOSP OR INSTITUTION	ITAL (If nat in haspita, give street	address)	d. STREET A	DDRES\$			a IS RE	SIDENCE A FARM?			
	SPRING	FIELD STATE HOSP	TTAL.	18	22 North	Charles St	roet	YES [NO 13			
	3 NAME OF DECEASED	First	Middle	Last	OF	71.0000		Day 8	Yeor 60			
	(Type or print)	Mary	Ethel	HANSON	DEAT				19 60			
	S. SEX	6. COLOR OR RACE 7. MARR	TIED NEVER MARRIED	B DATE OF BIRTH	100	9. AGE (In years lost birthday)		YEAR IF UND	1			
٠,	Female	White WIDOW	DIVORCED	2-14-7	880	79115.	W.Onlins	Duys Hours	PPMI			
	10a USUAL OCCUPAT	ION (Give kind of work dane 10b. rking life, even if retired)	KIND OF BUSINESS OR INC	DUSTRY 11. 8IRTHPL	ACE (State or foreign	country)/	12 CITIZ	EN OF WHAT	COUNTRY?			
	Housewor			Mar	yland		Ū	.S.A.				
	13. FATHER'S NAME			14 MOTHER'S	MAIDEN NAME							
	Charles H	anson		Mary	A. Adams							
	IS. WAS DECEASED BY	ER IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO	INFORMANT		Addi	ress					
	Jo	(it july give was as about as above)	9	S.S.H. Rec	ords							
	18. CAUSE OF DE	ATH [Enter only one couse per lin	ne for (a), (b), and (c).]		_			INTERVAL B				
	PART I. DEATH WAS CAUSED BY: Coronary Occlusion											
	420.0	DUE TO										
	Canditions, if	any, which) Ar	terioscleroti	c Heart D	isease			Years	1			
	gave rise to immediate											
	lying cause lost	couse (a), staring the <u>under-</u>										
		THER SIGNIFICANT CONDITIONS O	ONTRIBUTING TO DEATH B	UT NOT RELATED TO	THE TERMINAL DISEA	ASE CONDITION GIV	EN IN PART	1(o) 19 WAS	AUTOPSY			
e di	S Chronic	brain syndrome a sychotic reaction	ssociated wit	h cerebra	l arterio	sclerosis	with	PERF	ORMED?			
	PART II O' Chronic D 200. ACCIDENT W OR CONTRIBUTION (If EITHER, NOTIF	/AS UNDERLYING ☐ 20b. DESI G ☐ CAUSE OF DEATH Y MEDICAL EXAMINER	CRIBE HOW INJURY OCCUR	RED. (Enter noture of	finjury in Port I or P	ort II of ilem 18.}						
			THIRT OCCUPATED 20.	BLACE OF INDURY A	lome, form, 20f (C	1h h N	10		184-4-1			
	Hour o.m.	While	Not while	factory, street, office		ily or tawn)	(Co	ounty)	(State)			
		u won	k ot work	50	17-1	0(6						
		hat I attended the deceas				ry 8 ., 19 <u>6</u> 0						
	alive an Fe	oruary 7 , 19	60, and that dea	th accurred at_					d abave.			
	ACTUAL	and the coll	1. (an ha			(Street, city or town,		DA.	IE SIGNED			
	SIGNATURE	grandi ca	E CATTERS	M.D. Spri	ngfield S	tate Hosp:	ital	2	<u>-6-60</u>			
1	PHYSICIAN'S	gustin del Camp	o. M. D.	C1		Land Power						
					sville, M							
	REMOVAL (Specify	ON, 22b. DATE THEREOF	22c. NAME OF CEMETERY	1 1 /	22d LOC	ATION (City, fown,	11 /1	(Sto	ite]			
	Burial	2-10-60	Wew (athed	ral (em.	Do	altimore						
4	23. FUNERAL DIRECTO	0 0 1	ADDRESS		240. REC'D BY REG		STRAR'S SIG	NATURE				
1	Leonard	4. Ruck 5305 t	Harford Rd		DATE FEB 1 0	60 C	Thun 8	H				

moy be retoined by the tospitol or forming physicion.

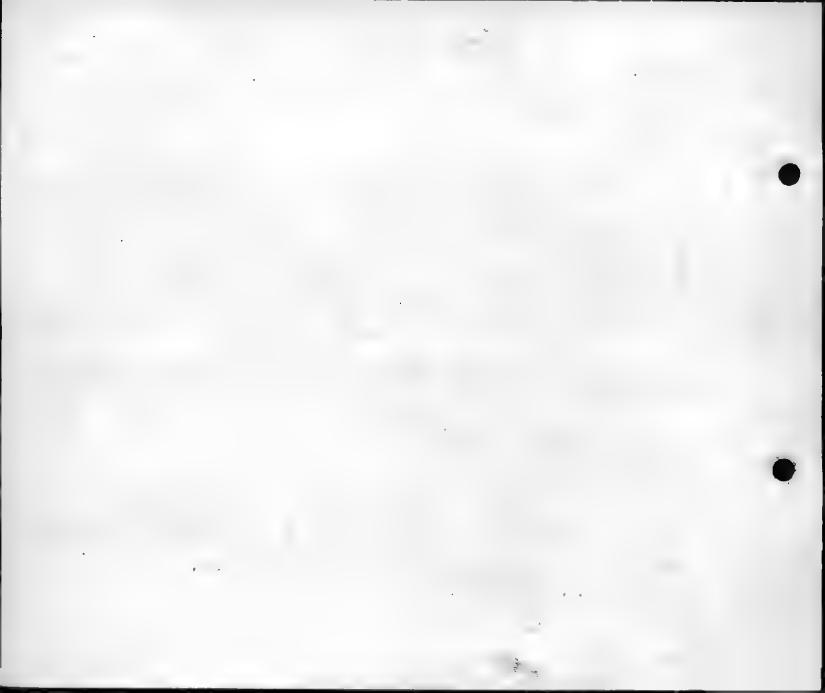
TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit perm t. Then please remove corbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. hours ofter death. Page 4 N: The low requires that the death certificate be executed with TO HOSPITAL OR ATTENDING PHYS

VS A15 (4) 1SM 9/SB



VS A15 (4) 15M 9/58

	_	1023		Keg. Dist. No.						
	1. 1	CE OF DEATH COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Resider STATE MARYLAND D COUNTY B					pefore admission)			
	ı	RURAly and give nearest town)	OF STAY IN 16	c. CHY OR TOWN (IF a	sutside corporate limits, wr	ite RURAL and give	nearest town)			
	d. NAME OF HOSPFIAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO				
3. NAME OF DECEASED (Type or print) JOHN - T - HARRIS 15 Last 4. DATE OF DEATH Heb 2										
	5. 5	6. COLOR OR RACE 7. MARRIED NEW WIDOWED	444	Months Days Hours Min.						
1	10a	. USUAL OCCUPATION (Give kind of work dane 10b, KIND OF Biduring most of working life, even if setired)	STRY 11. BIRTHPLACE (Stote		TIZEN OF WHAT COUNTRY?					
1	13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	IAME .					
		William M Harro)	Mary.	Palizzo	ud				
		WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SEC.	-4306C	itherine 2	P. Wolfe-	Hauf.	stead Ma			
			INTERVAL BETWEEN ONSET AND DEATH TO MILM							
		PART I. DEATH WAS CAUSED BY GOTONARY	Thrombo	sis			10 min			
			8 yrs							
			O yrs							
		couse (a), stating the <u>under-</u> lying couse last. Co								
	Š.	GIVEN IN PART 1(19. WAS AUTOPSY							
14	CAT	Old Cerebral Thrombosis								
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO OID COPE TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERFO YES TO THE TERMINAL DISEASE CONDITION GIVEN THE TERMINAL DISEASE CONDITION GI									
	MEDICAL	20c TIME OF INJURY Month, Day, Year 20d, INJURY OCC Hour o. m. 19 at work at work at work at work	rhile for	ACE OF INJURY (Hame, form tory, street, affice bldg., etc.		(Cour	nly) (State)			
	_	21. I certify that I attended the deceased from	June	19 58 to	February, 29	1960t Llast	saw the deceased			
		Fohmunge 1 60	and that death	-pccurred at 3p	M, from the causes					
		ACTUAL M. C. Chatta	Do od	/	ADDRESS (Street, city or fi	own, state)	DATE SIGNED			
1		SIGNATURE / / CONTROL OF	acq	M.D. Ham	ostead, Md.		2/2/4			
1		PHYSICIAN'S M.C. Porterfield,	D. (
	220	BUR.AL, CREMATION, 27b. DATE THEREOF 22c, NAM 24 (Specify) 2-6-60	LE OF CEMETERY O	R CREMATORY ELLO	22d LOCATION (City, to	(()	Wed (State)			
	23	FONERAL DIRECTOR'S SIGNATURE ADDR	RESS	20.0		REGISTRAR'S SIGNA	_			
Ceall Elipton of authorition Ma DATEFEB 5 '60 ariling & King										



IS RESIDENCE

ON A FARM?

Day

19

IF JNDER I YEAR IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES INO I

> > (State)

DATE SIGNED

2-19-60

(State)

Days

TISA

(County)

YES NO T

Year

60 19

Reg. Dist. No.

Months

220. BURIAL, CREMATION, 226. DATE THEREOF REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE

22c. NAME OF CEMETERY OR CREMATORY ADDRESS

24a, REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE Curing S. Thomas

0 VS A15 (4) 15M 9/SB



y the funeral directar, 2 should be filed with

i. The faw requires that the death certificate be executed with a physician. moy be retained by the hospital ar

TO FUNERAL DIRECTOR: After this can
page 3 should be detached for use at
the State Board af Health prior to bur TO HOSPITAL OR ATTENDING PHYS

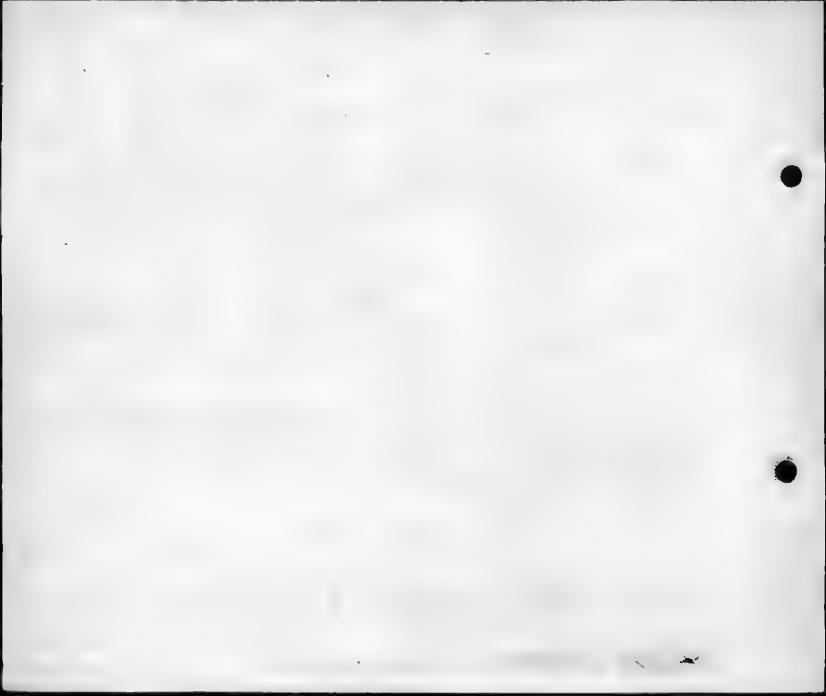
VR ATS (4) TSM 9/59

9	P	4	
.=	ä		
ed	-	غ	
臣	ge	60	
10	2	D	
e	10	Fe .	
G.	per	V	
00	pd	1	Т
P	c	1	T
0	ě	1	1
ğ	8	·Ē\	_
15.6	Ye	·\$	
Ph)	E	ť	
D	2	e < e	
ġ.	OSe	7	
ie.	ple	P	
6	E	.=	
tracate has been signed by the attending physician and completely filled in b	s the burial-transit permit. Then please remave carbon papers. Pages I and	ial, cremation, ar removal, and in any event, within 72-boxes after deat	
þ	_		
D	Ē	20	
ů.	per	Ě	
. 42	Ξ	-	
Ge C	ani.	0	
Ď	=	6	
has	P	g	
e	20	e l	
0	e	0	
1	-	D	

	1836 CERTIFICATE OF DEATH									
	1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY I and I ontonery							
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	Lyrs m 10 da	b c. CITY OR TOWN (If outside corporate timits, write RURAL and give nearest							
7	d NAME OF HOSPITAL (If not in hospitol, give street of R INSTITUTION Springfield State Hospi	ital	d. STREET A	1			e. IS RESIDENCE ON A FARM? YES NO			
	3. NAME OF First DECEASED (Type or print) Ella	Josephine	XXXXXX	XXXX DEAT		th D	Day Year 6 19 60			
	s. sex 6. color or race 7. marri	D DIVORCED	J	XXX1880	9. AGE (In years	Manys Days	IF UNDER 24 HRS Hours Min			
1		WIND OF BUSINESS OR INDU		ACE (State or foreign	country)		F WHAT COUNTRY			
/	13. FATHER'S NAME Philipp Jacobs 14. MOTHER'S MAIDEN NAME Sophie Kettlekamp									
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? [16, 5] (Yes, no, or unknown) [If yes, give wor or dates of service] NO	unkn	NFORMANT Hospita	1 Records	Addr	ess				
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] PART I. DEATH WAS CAUSED BY: Cheumatic heart disease inactive, with mitral stens DUE TO Conditions, if ony, which gove rise to immediate couse (a), stoting the under: Lying couse lost. [C] INTERVAL BETT ONSET AND I YEARS Vears ONSET AND I YEARS ONSET AN										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN N PART C. R.S. assoc. with circulat. disturbance with cerebral arterioscleresis with psych. reaction 200 ACCIDENT WAS UNDERLYING OF DEATH OR CONTRIBUTING OF CAUSE OF DEATH 201 OR CONTRIBUTING OF CAUSE OF DEATH 202 OR CONTRIBUTING OF CAUSE OF DEATH 203 OR CONTRIBUTING OF CAUSE OF DEATH 204 OR CONTRIBUTING OF CAUSE OF DEATH 205 OR CONTRIBUTING OF CAUSE OF DEATH 206 OR CONTRIBUTING OF CAUSE OF DEATH 207 OR CONTRIBUTING OF CAUSE OF DEATH 208 OR CONTRIBUTING OF CAUSE OF DEATH 208 OR CONTRIBUTING OF CAUSE OF DEATH 209 OR CONTRIBUTING OF CAUSE OF DEATH 200 OR CONTRIBUTING OF CAUSE OF DEATH 201 OR CONTRIBUTING OF CAUSE OF DEATH 201 OR CONTRIBUTING OF CAUSE OF DEATH 202 OR CONTRIBUTING OF CAUSE OF DEATH 203 OR CONTRIBUTING OF CAUSE OF DEATH 204 OR CONTRIBUTING OF CAUSE OF DEATH 205 OR CONTRIBUTING OF CAUSE OF DEATH 206 OR CONTRIBUTING OF CAUSE OF DEATH 207 OR CONTRIBUTING OF CAUSE OF DEATH 208 OR CONTRIBUTING OF CAUSE OF DEATH 208 OR CONTRIBUTING OF CAUSE OF DEATH 208 OR CONTRIBUTING OF CAUSE OF DEATH 209 OR CONTRIBUTING OF CAUSE OF DEATH 200 OR CONTRIBUTING OF CAUSE OF DEATH 201 OR CONTRIBUTING OF CAUSE OF DEATH 201 OR CONTRIBUTING OF CAUSE OF DEATH 202 OR CONTRIBUTING OF CAUSE OF DEATH 203 OR CONTRIBUTING OF CAUSE OF DEATH 204 OR CONTRIBUTING OF CAUSE OF DEATH 205 OR CONTRIBUTING OF CAUSE OF DEATH 206 OR CONTRIBUTING OF CAUSE										
	20c. TIME OF INJURY Month, Doy, Year 20d. IN Hour o. m. While of work	(County)	(Stote							
/	21 I certify that (I) (this haspital) attended saw the deceased alive an 3-0-20 Signature 22c. Physician's NAME (Type) Edimund Itusthaus	19.60, and that	M.D ATTENDING PHYS 22d. ADDRI	d a6;20M, Rican	STAFF X	d an the date	stated above 22b.DATE 2-7-00			
	Burial 236 DATE THEREOF 236 NAME OF CEMETERY OR CREMATORY Arlington, Virginia (Stote) Arlington Nat'l Cem. 23d. LOCALON (City, 10wm, or county) ginia (Stote)									
	24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, B	ethesda, Ma	ryland	DATE FER 9	100	TRAR'S SIGNATU				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



with

should be filled

in by the fand

and completely filled

oug

Pages 1 ofter death.

event, within

any

puo

removal.

buriol, crematian, or

funeral director,

TO FUNERAL DIRECTOR: After this cert ficate page 3 shauld be detached for use the State Board of Health prior to by TO HOSPITAL OR ATTENDING PHY may be retained by the haspital

_												
	RURAL and give nearest town)			MARY	LAND	2. USUAL RESIDENCE (WH	ere decease	b. COUNTY			1	(on)
<u> </u>						Maryland Baltimore City						
				c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and				give nec	rest town	1)		
	Sykesvill			lyr.4mo.20day		\$ Baltimore					./ -	
	d. NAME OF HOSPITA	oddress)		d. STREET ADDRESS						IDENCE		
	Springfie	ital		825 N. Mount Street					YES N			
3	NAME OF	First		Middle		Lost 4. DATE		Manth		Do	y	Yeor
	DECEASED (Type or print)	Sara	h		Ho	re Isaacson	OF DEATH	Februar	Y7.	7.0	1	1960
5	SEX	6. COLOR OR RACE	110	RIED NEVER MARRIE		B. DATE OF BIRTH		9. AGE (In years	788	RIYEAR		R 24 HRS
7	?emale	White	WIDOWI	_		April 18, 18	61,	lost birthdoy)	Months	Days	Hours	Min
				60	<u> </u>				32 CI	ELZENIOE	WHATC	OUNTRY?
100	JSUA: OCCUPATION (Give kind of work done during most of working life, even if retired))	IND. KIND OF BUSINESS OR INDUS				.,				
_	Housewife									ien (Russia		sla)
13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME											
	Samuel Ha	Samuel Hare Unknown										
		IN U. S ARMED FOR		SOCIAL SECURITY NO	. 17. 10	NFORMANT		Addr	ess			
	No	m yes, give war or dates or s		None	Sp	ringfield Hos	pital	records				
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)]									INTERVAL BETWEEN		
	PART I DEA	PART I DEATH WAS CAUSED BY Arteriosclerotic cardiovascular disease							years			
									-	CCIA D		
	422.1 DUE TO											
	Conditions, if any, which (b)								+			
	couse (a), stoting the under- DUE TO											
l _	lying couse last.) (c										
0 N	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED?											
3	Ps.	vchosis wi	th ce	rebral arte	erio	sclerosis					YES 🗌	NO F
CERTIFICATION	200 ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
MEDICAL	20c. TIME OF INJURY Hour o. m. p.m.	18							(State)			
	21. I certify tha	t (I) (this hospital) attend	led the deceased	fram.	March 7 . 19	55.10_	rebruary	1919	60, th	at (I) (we) as

1820

60, and that death occurred at 3:1167, from the causes and on the date stated above saw the deceased alive an. 22b DATE 19/60 ATTENDING PHYS MED DIRECTOR STAFF M.D 722c. PHYSICIAN'S NAME (Type) 22d ADDRESS del Carpo, Agustin Springfield State Hospital, Sykesville, Md. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) 23a BURIAL, CREMATION, (Stote)

curia

PREMOVAL (Specify)

ADDRESS EUTAW 25a REC'D BY REGISTRAR

256 REGISTRAR'S SIGNATURE

DATE FEB 2 3 160 Orthon & House

VR A15 (4) 15M 9/S9



e, IS RESIDENCE ON A FARM?

YES NO E

Yeor

19 60

Carroll

Day

26

INTERVAL BE VICEDIO

YES K

(County)

24b. REGISTRAR'S SIGNATURE

arilar & Frank

240. REC'D BY REGISTRAR

WAS AUTOPSY PERFORMED?

DATE SIGNED

(Slote)

2/27/60

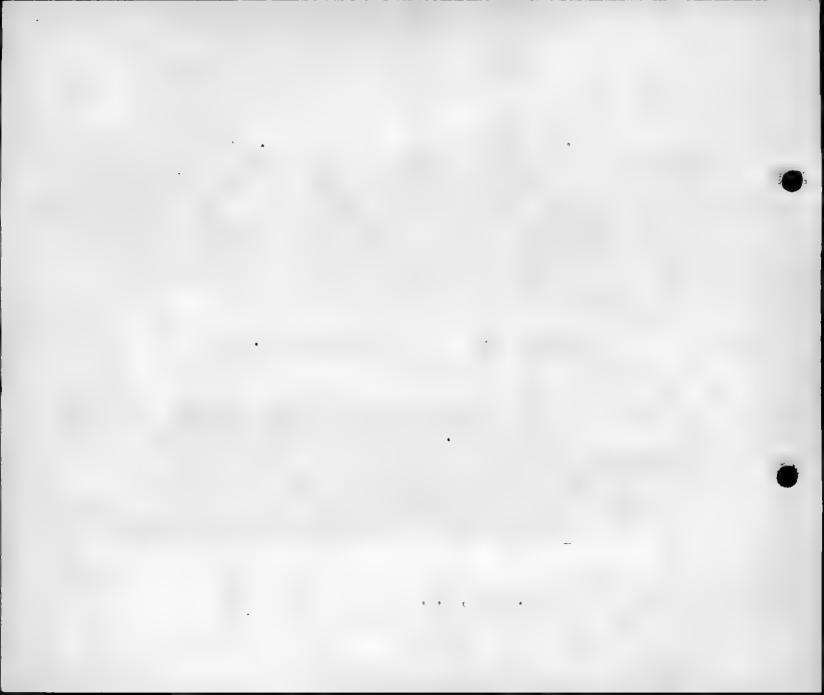
NO 🗆

(State)

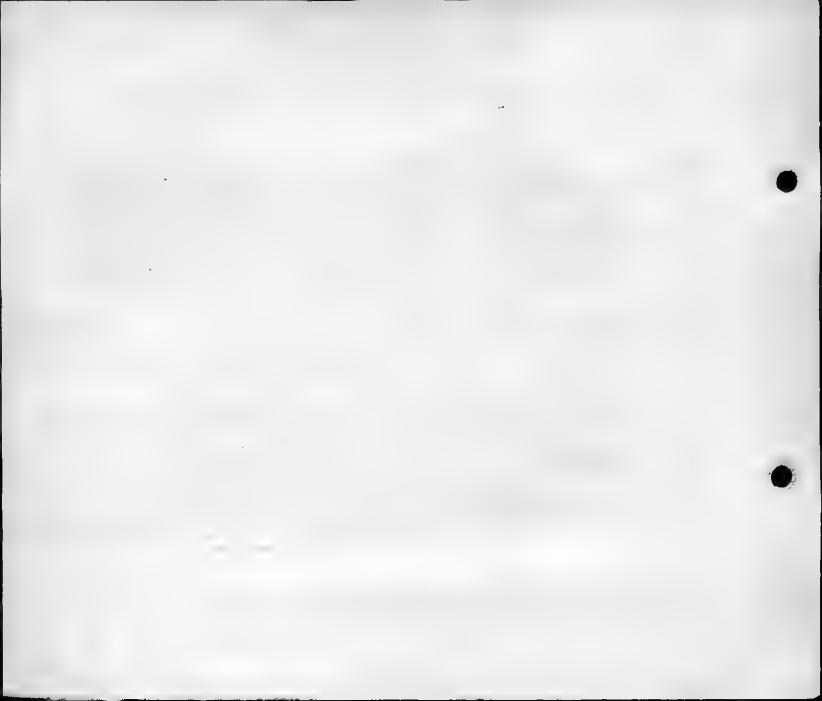
Days

VS. A15ME(5) 5M 9/55

BUNERAL DIRECTOR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

	. COUNTY		- 4		2.	USUAL RESIDENCE	(Where de			an- Kesideni	e betoi	e odmiss	ion)
	Carro	11		ROUTO			ylanc	1	o. COUNTY	Cit	У	25	- 4
	CITY OR TOWN (I	f outside carporate lim	its, write	c LENGTH OF STAY IN	1b	c. CITY OR TOWN	If autside	corporate lin	nits, write Ri	URAL and g	ive neo	rest tawr)
	Sykesyi			5 mths 3	days	Balt	imore	23.M	i.		3	V :	1
	d. NAME OF HOSPIT	AL (If nat in haspital,	give street a			d. STREET ADDRESS						a. IS RES	DENCE FARM?
	Springfi	eld Sate H	ospita	al		1830 -ams	say S	Street					NO 🕞
3.	NAME OF DECEASED	Fi	rst	Middle		Last		ATE	Mon	th	Do	γ ,	lear .
	(Type or print)	Freda		Susanna		Kaiser	Ď	OF DEATH	2		27		19 60
5 5	SEX	6. COLOR OR RACE	7- MARRI	ED V NEVER MARRIED	8. 0	ATE OF BIRTH			E (In years	IF UNDER		IF UNDE	R 24 HRS
	Female	White	WIDOWE	DIVORCED [_	6-25-06		5	birthday) 2 yrs	Months	Days	Hours	Min.
10o	USUAL OCCUPATIO	N (Give kind of work	done 10b. k	CIND OF BUSINESS OR I	NDUSTRY	11. BIRTHPLACE (St	ole or for	reign country)	<i></i>	12.CITI	ZEN OF	WHATC	QUNTRY?
		ing life, even if retired	}			Manag	1 1				II.S		
13.	Nurse FATHER'S NAME				1	4 MOTHER'S MAIDE					تنهالا	-th-	
15	WAS DECEASED EVE	R IN U. S. ARMED FOI	RCES? I.A. S	OCIAL SECURITY NO.	17 INFO	Charlot	te Gr	COSSDA	Addr	ess			
		If yes, give wer or dates of	service)			0.77	R						
-	AL CAUSE OF STA	ma fe		5-09-4168	<u>s.</u>	S.Hospita	L ec	cords			In other	Dece De	TAREERI
		TH WAS CAUSED BY:		e for (o), (b), and (c).]							ONS	RYAL BE	DEATH
	12 TAN 11 DEA	IMMEDIATE CAUSE (Pre:	<u>senile Scler</u>	cosis	(Alzheime)	r Di	sease)		y y	ears	
	~ ~ ~ ~ ~ ~	DUE TO									1		
	Conditions, if or)										
	gove rise to it couse (a), stating									fts.			
	lying couse lost.) (:)										
CERTIFICATION	PART II OTH	IER S.GNIFICANT CON	IDIT ONS CO	ONTRIBUTING TO DEATH	BUT NO	T RELATED TO THE TE	RMINAL	ISEASE CON	D TION GIV	ENUN PART	1(a) 1	9 WAS	ALTOPSY RMED?
CAT	1 1 1 1		ction	er disease,	Die	betes Mel	litus	FOSTS	PHARLET !!	Mark 3			NO 🗹
THE	20a ACCIDENT WA			RIBE HOW INJURY OCC					item 18 }				
		MEDICAL EXAMINER)	101	16 W 6 1									
MEDICAL	20c TIME OF INJUR	Y Month, Day, Ye	or 20d IN	JURY OCCURRED 20		OF INJURY (Home, f		f. (City or to	~n)	(0	ounty)		(State)
VEDI	Hour o.m.	19	While of work	Nat while	tactory	r, street, affice bldg ,	erc.]						
~		A #12 #4b b22				9-24-	159	2-3	27-	10.6	Ω	-1.40.4	we) last
	,			ed the deceased fr				1.14					
	220 SIGNATURE	ed alive an2	<u> </u>	19_60, and th	nat dea	th accurred ats_	P T 16/8' T	from the c	auses an	d an the	dote		DATE
	Tela.		Per-	Man	. un	ATTENDING	MED.	STA	YS 🏝				3)07 E &
	22c PHYSICIAN'S		i na Charle	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M.D	22d ADDRESS	DIRECTO	JK PH	13				
	NAME (Type)	dmund Taist	haus l	M.D.		Springf	ield	State	Hospi	tal.S	vke	svil	le.Md
		THE PERSON NAMED OF											

BUR AL CREMATION, REMOVAL (Specify)

3 /2/6

Par LIWOO &

(Stote)

01826

24 FUNERAL DIRECTOR'S SIGNATURE

2So. REC'D BY REGISTRAR DATE

256 REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYS VR A1S (4) 1SM 9/59



DATE FEB 1 8 '60

Circling & France

M. R. Etchison & Son, Frederick, Maryland

VS. A15ME(5) 5M 9/55

DEPUTY MIDICA



01

hours after death. Page.4

VR A1S (4) ISM 9/59

	DIAISIC	835		TE OF DEAT		MAKILAND			113	360
	ACE OF DEATH COUNTY Carroll		MARYLAND	2 USUAL RESIDENCE (* o STATE Mary]		d lived If institution b COUNTY				
ь	CITY OR TOWN (If outside corporate limits RJRAL and give dearest town) TRESVILLE	, write c. U	ength of STAY IN 16	c. CITY OR TOWN (I		prote limits, write R	URAL one	give near	est town)
	NAME OF HOSPITAL (If not in haspital, gir OR INSTITUTION Or INSTITUTION		ss}	Route # 2	Middle	town				FARM?
DI	AME OF CEASED Willi	am	Elmer	Kinna	4. DATE OF DEATH	Mon 2	th	'n	1	^{Year} 60
S. SE	_	MARRIED (DIVORCED	B. DATE OF BIRTH 1-9-1874		9 AGE (In years lost birthday) 90 yrs	Months Months	Doys Doys	Hours	R 24 HRS Min
	USLAL OCCUPATION (Give kind of work de during most of working life, even if retired) ired independent far		OF BUSINESS OR INDU	STRY II BIRTHPLACE (SIG		country)	12. C	U.S.A		OUNTRY
13. F/	David E.Kinna			14. MOTHER'S MAIDER	Mahala	Fisher				
	(AS DECEASED EVER IN U. S. ARMED FORCE (If yes, give wor or dates of ser	vica)		NFORMANT Hospital reco	ords	Add	ress			
	B. CAUSE OF DEATH {Enter only one cau PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).	MILL	alt Aprilia	Valve 5	teno.	515			ET AND	
	Conditions, if any, which) (b).	Heart	Dis	ease		4	ec.	rs		
	gove rise to immediate couse (a), stating the under-lying couse last (c)									
CATION	El Davido agra lilita como histori lla halara Calabase C								RMED?	
E.	NO ACCIDENT WAS LINDEBLYING TO	ONL DESCRIBE	HOW INHIBY OCCUPA	D. (Enter nature of miney	in Part Lor Po	et ill of item 18.1				

OR CONTRIBUTING | CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER

MEDICAL TIME OF INJURY Doy, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, Year Hour o. m. While Not while ot work at work p m

20f (City or town) factory, street, office bldg., etc.)

21 I certify that (I) (this haspital) attended the deceased fram2-10 19 60 to 2-1 that (I) (we) last saw the deceased alive an. and that death accurred at causes and on the date stated abave 226 DATE 2-111-60 SIGNATURE STAFF PHYS. ATTENDING PHYS MED DIRECTOR

M.D. 22c. PHYSICIAN'S Agustin del Campo.M.D.

22d. ADDRESS Springfield State Hospital Sykesville Md.

DATE THEREOF 23c NAME OF GEMETERY OR CREMATORY LOCATION (City towns or county) BURIAL CREMATION, 236 REMOVAL (Specify) Y-1 25a. REC'D BY REGISTRAR

24 FUNERAL DIRECTOR'S SIGNATURE

DEEB 1 7 '60

Orthur S. Kraus

(County)

(Slote)



朝

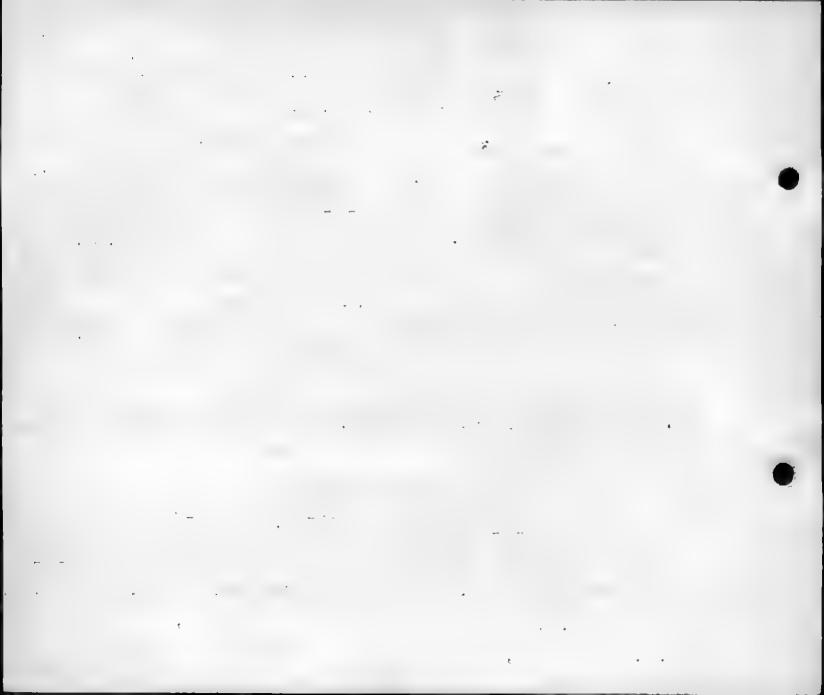
0

1. PLACE OF DEATH

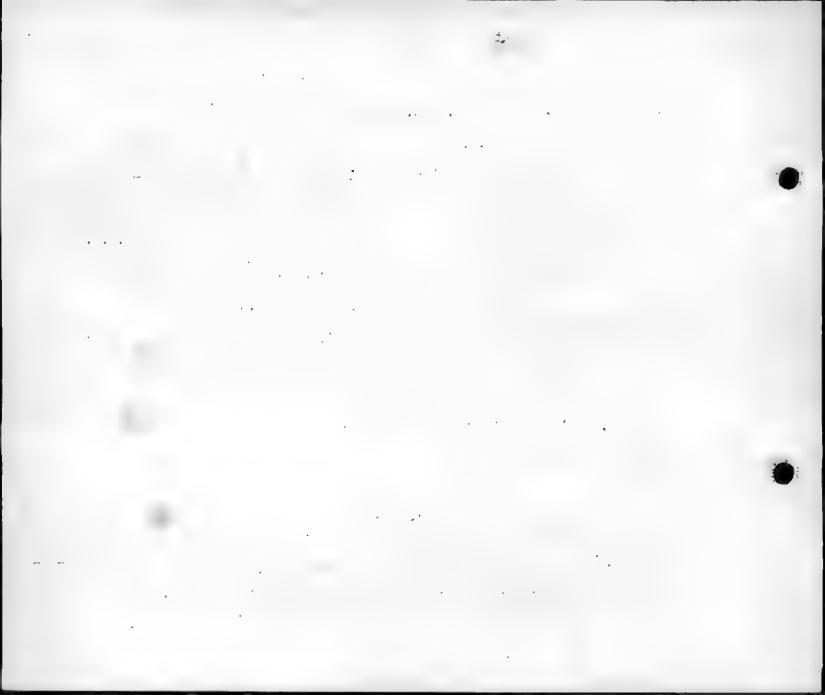
DIVISION 18

OF STATISTIC	ND STATE DEPARTMENT OF HEALTH CAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH	01829
	2. USUAL RESIDENCE (Where deceased lived. If institution: Residen	ce before admission)

Carroll	MARYLAND	o. STATE Maryl	and	b. COUNTY	Freder	ick	L
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF		rote limits, write Rt	RAL and give	nearest tow	m)
Sykesville	30 y 1 m 6 day	s Frederic	k	/	011.	A.,	
d NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION	ocidress)	d STREET ADDRESS					SIDENCE A FARM?
Springfield State Hospi	tal	115 East	4th St	reet		YES [NO 💽
3 NAME OF First	Middle	Last	4. DATE OF	Monl	h	Day	Yeor
(Type or print) Mary	Agnes	Krepps	DEATH	2		12	1960
5. SEX 6. COLOR OR RACE 7 MARI	RIED NEVER MARRIED 8	L DATE OF BIRTH		9. AGE (In years lost birthday)	Months Doy		
Fem White WIDOW	ED DIVORCED	4-29-68		91 yrs.	monns boy	rs Hours	William
10a USUAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired)	KIND OF BUSINESS OR INDUST	TRY 11 BIRTHPLACE (Stote	e or foreign c	ountry)	12 CITIZEN	OF WHAT	COUNTRY?
Saleslady	Dept. Store	Maryl	and .		U.	S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME				
Solomon Garber		Isabell	Brigh	twell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Yes, no. or unknown) (If yes, give war or dates of service)		FORMANT	II.	Addr	BSS		
in you, got that of allow or to the	None	S.S.Hospital	ecor	ds			
18. CAUSE OF DEATH [Enter only one couse per li	ine for (o), (b), and (c).]					NTERVAL B	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) T	hrombocytopenic	purpura				year	
2.46 X DUE TO						_	
Conditions, if ony, which gove rise to immediate couse (o), stating the under-lying couse lost. (c)							_
7 101	contributing to DEATH BUT I	YOU RELATED TO THE TERM	MINAL DISEAS	E CONDITION GIV	EN IN PART 1(c) 19 WAS PERFO YES	ALTOPSY ORMED? NO 2
PART II OTHER SIGNIFICANT COND TIONS Hanic depressive react. 200 ACCIDENT WAS UNDERLYING OF CONTRIBUTING OF CAUSE OF DEATH OR CONTRIBUTING OF CAUSE OF DEATH HOUR O. m. 19 While of wor	CRIBE HOW INJURY OCCURRED	(Enter noture of injury in	Port I or Por	t II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year 20d. I Hour o. m. While p. m. 19	Not while foch	CE OF INJURY (Home, for ory, street, office bldg., e		or town)	(Cour	ity)	(Stote)
21 I certify that (I) (this haspital patterns say the deceased alive an 2-12-			9.54 to _	2-12- the couses an	, 19 <u>60_,</u> d on the do	that (1) ate state	(we) lost d above.
220. MGIVATURE	thouse	A D. PHYS	MED. DIRECTOR [STAFF A		2 2	26 DATE SIGNED -13-60
22c PHYSICIAN'S Edmund Lusthaus	M. D.	Springfie	eld Sta	te Hospi	tal, Sy	kesvi	lle, Md
230. BURIAL, CREMATION, PREMOVAL (Specify) Burial Feb.16,1960	23c NAME OF CEMETERY OR Mount Olivet			TION (City, town, clerick,		rylan	id
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, F	ADDRESS rederick, Maryl		EB 1 6 6		TRAR'S SIGNA		



ISM 9/58



death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, TO



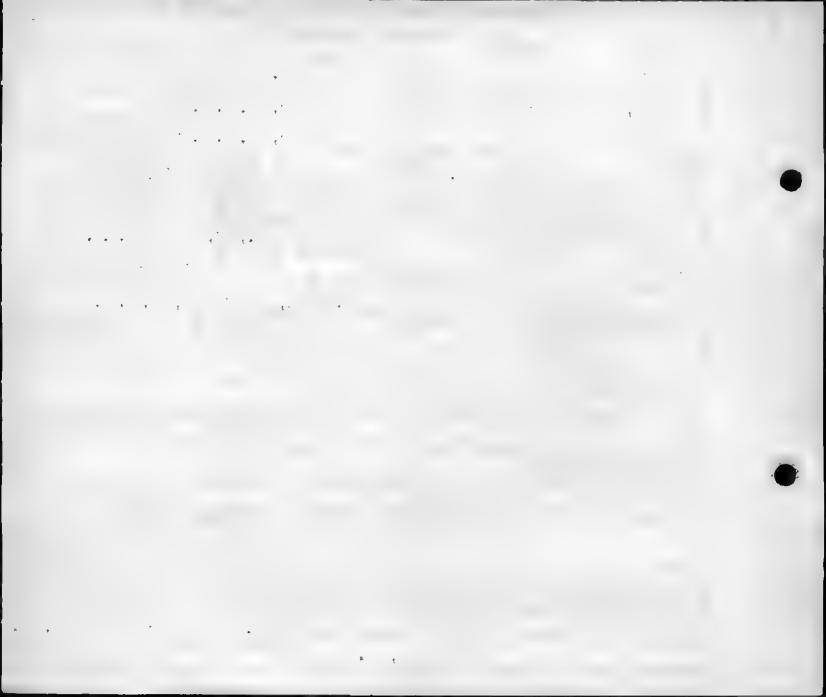
VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Rea. Dist. No. Adams IS RESIDENCE ON A FARM? YES NO Year

(State)

Ciring S. Thous

2/11/60 19 IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years 77 fost birthday) Days 12. CITIZEN OF WHAT COUNTRY? U.S.A. Mary Ellen Fridinger Address Roy D. Leese. Westminster. Md. R. D. 2 INTERVAL BETWEEN ONSET AND DEATH PERFORMED? YES NO 🗍 [County] (Stote) . 1918, to 2 - 1814 GA 1960, that I last saw the deceased ADDRESS (Street, city or town, state)



22c. NAME OF CEMETERY OR CREMATORY

01853

e. IS RESIDENCE

Day

Haurs

INTERVAL BETWEEN 2 hou

> PERFORMED YES [NO

> > (State)

12. CITIZEN OF WHAT COUNTRY?

Days

(County)

22d JOCATION (City, fawn, or county).

24a, REC'D BY REGISTRAR

'60

24b. REGISTRAR'S SIGNATURE

allung & Krous

ON A FARM?

YES NO

Year

196-0

9 VS A15 (4)

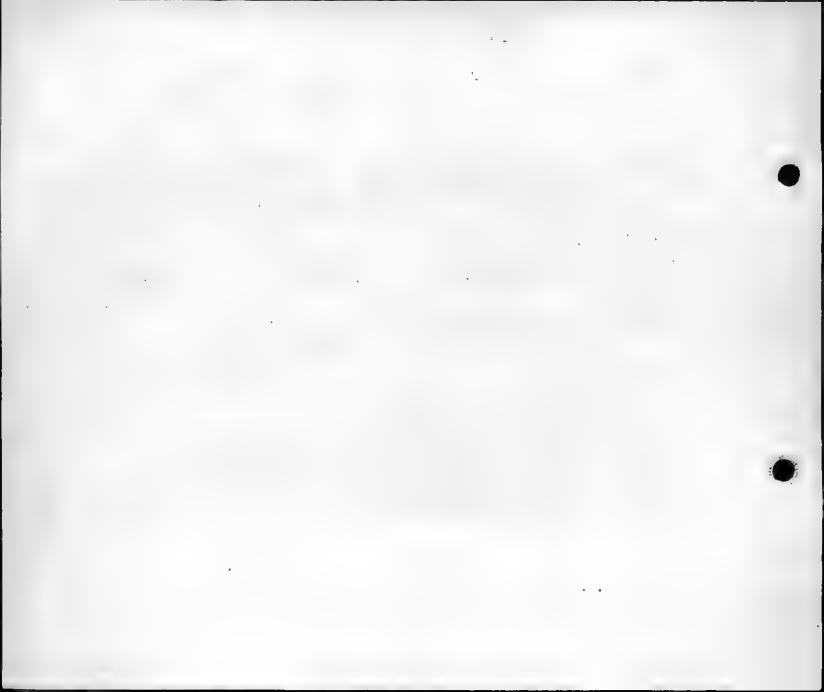
15M 9/58

page

22a. BURIAL CREMATION.

REMOVAL (Spesify)

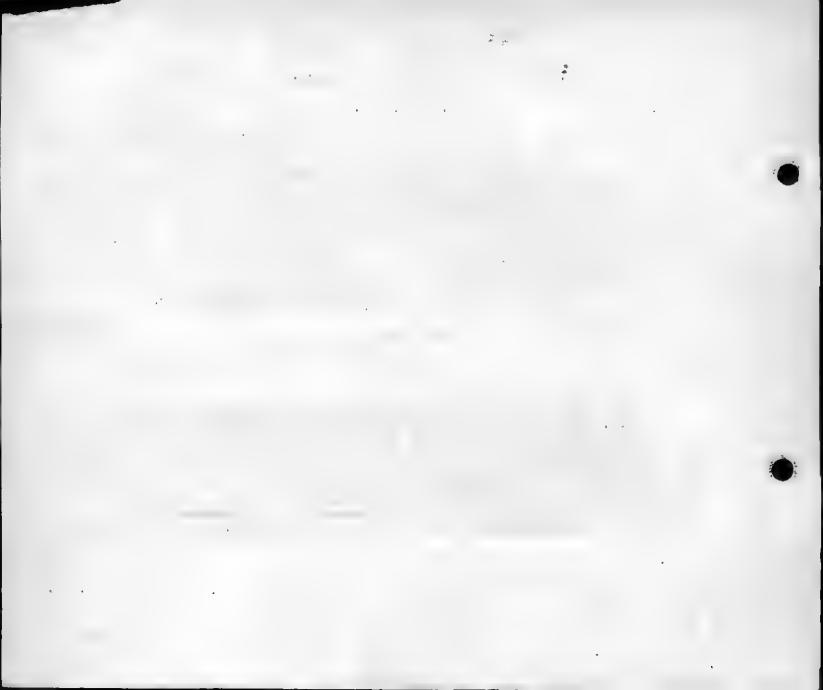
FLINERAL DIRECTOR'S SIGNATURE



VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2842 CERTIFICATE OF DEATH 01854

1	, PLACE OF DEATH					2 USUAL RESIDENCE (W	Vhere decease			before admi	ssian)	
	Carroll			MARYLA	ND	Mary land		b county Balt	imore	City		
	b CITY OR TOWN (III RURAL and give no	foutside corporate lim arest town)	its, write c.	LENGTH OF STAY IN		c. CITY OR TOWN (IF	outside corpo	prote limits, write R	URAL and giv	ve nearest tav	vn)	
	Sykesvil		[]	. yr. 7 mo.	. 27	dBaltimore		,	EV 1	4		
_	d NAME OF HOSPIT OR INSTITUTION	AL (If not in haspital, i	give street ado	lress)		d STREET ADDRESS				e. IS RE	SIDENCE A FARM?	
L		eld State	dospita	1		915 East 1	Baltime	ore Stree	it		NOM	
3	NAME OF DECEASED	Fi	rşi	Middle		Last	4. DATE OF	Mon	ith	Doy	Year	
	(Type or print)	Aı	nna	Rubin		Levitz	DEATH	Februar	У	3	19 60	
5	. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	□ 8	DATE OF BIRTH		9. AGE (In years lost to rthday)		YEAR IF UND	1	
	Female	white	WIDOWED	DIVORCED		1878	6	83 yrs	Months D	Poys Hours	Min.	
1	On. USUAL OCCUPATION during most of work	N (Give kind of work ing life, even if retired	done 10b. Kih	ND OF BUSINESS OR	INDUST	RY 11. BIRTHPLACE (Stot	le or foreign c	country) ~	12. CITIZI	EN OF WHAT	COUNTRY?	
	housewi		"	_		Batvi	A.		U.	S.A.		
1	3 FATHER'S NAME	· MI	11	12 .		14. MOTHER'S MAIDEN	NAME		/			
	Mres	el IV.	Du	ben		TUST 1	Carson	ww				
	5. WAS DECEASED EVE	R IN U. S. ARMED FOI		CIAL SECURITY NO.	17, INF	ORMANT		Add	ress			
I,	No	ess. give war or ours or		ne	S	Springfield Hospital Records						
F	18 CAUSE OF DEA	TH [Enter only one co	ouse per line f	or (a), (b), and (c).]			_			INTERVAL E	ETWEEN	
	PART ! DEA	TH WAS CAUSED BY. IMMEDIATE CAUSE (c	Bron	chopneumor	nia					ONSET AN	D DEATH	
-1	4491X	DUE TO										
	Conditions, if a	nv. which) "	,									
	gave rise to i	mmediote (· · · ·								
	lying couse last.	ine <u>under-</u>										
		IER SIGNIFICANT CON	·	STRIPLIENCE TO DEAT	H RelT N	NOT RELATED TO THE TER/	MINAL DISEAS	SE CONDITION GIV	VEN IN PART	1(a) 119. WAS	AUTOPSY	
	C.B.S.	. assoc. W.	ith dis	turbance d	of m	etabolism.	growth	or nutri	tion	PERF	ORMED?	
		senile bra	n dise	ase with	Syc	hotic react	ion	et II of Jam 18 1		its [] ио [Ж	
600	OR CONTRIBUTING	CAUSE OF DEATH MEDICAL EXAMINER)	ZVB. DESCRI	BE HOW INJURY OCC	UKKED	, (Enter nature at injury is	B FORT OF FO	it it or nem in-i				
1	20c. TIME OF INJUR Hour a. m.	Y Manth, Day, Ye	ar 20d INJL	JRY OCCURRED 2		CE OF INJURY (Home, for		y or lown)	{Cc	ounty)	(State)	
i.	Hour a.m.	19	While at work	Not while	rach	ary, street, affice bldg., e	(rc.)					
1		. 715 711 1 1				June 6 1	0.005 L. T	To have more	2 1060	N - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	4 > 1 - 1	
						eath accurred aff						
	22a/SIGNATURE	ed dive du'T-67	// 1	\$17,00, and ti	nar ae	an accurred at 13	QUVI,*4FORI	The couses or	id on the		25 DATE	
	Edm	und;	Lus	Than	» N	.D. ATTENDING	MED DIRECTOR	STAFF PHYS	,	2	1/3/60	
	22c PHYSICIAN'S NAME (Type)	77.2	.4.7	M D		22d ADDRESS						
	Total (1) pol	Edmund Lus	stnaus,	M.D.		Springfie	eld Ho	spital, S	ykesvi	lle, M	id.	
2	30 BURIAL CREMAT O	N, 236 DATE THERE	PF 2	3c SAME OF CEMET	ERY OR	CREMATORY	23d LOCA	TION (C ty Javn,	or cauniy)	(54	ole)	
1	BEMOVAL (Specific	2-4-6	0	Herry	g	terno		150	Xto	74	al	
2	UNERAL DIRECTOR	SIGNATURE		ABORESS	(1)	27 25a. RE	C'D BY REGIS	TRAR 25b REGI	ISTRAB'S SIG	NATURE		
1	facel be	wooms.	2100	Outain	1/	COST OFFI	4 '60	Chille	un S. Piro	UUA.		

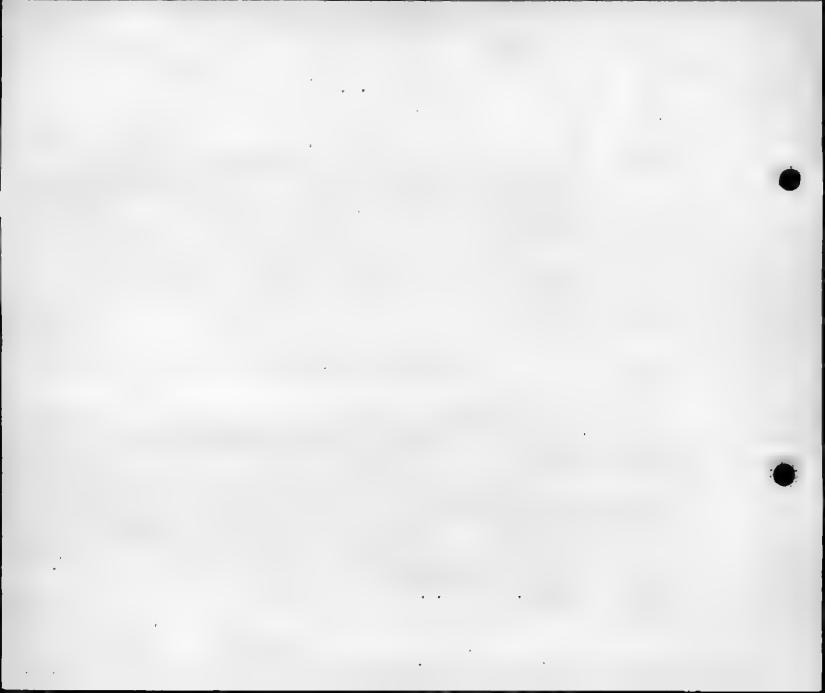


	•		N	
TO HOSPITAL OX ATTENDING PHYSE AN: The faw requires that the death certificate be executed with thaurs after death. Page 4 may be retained by the hospital at thing physician.	TO FUNERAL DIRECTOR: After this certained has been signed by the attending physician and campletely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be disched.	the registror prior to buriol, cremation, or removal, and in any event within 72-hours after death.		
may be retained by the hospital at ding physician.	TO FUNERAL DIRECTOR: After this certificate page 3 should be detached for use as the bu	the registrar priar ta burial, cremation, ar ren	, 10	
15M	10/5	7	1	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with

1 haurs ofter death. Page 4

1843 CERT					TE OF DEATH		Reg. Dist. No.					
1. PLACE OF DEATH g. COUNTY	CARROLL		MARYLA	ND	2. USUAL RESIDENCE (WHO STATE MARYLAND	ere deceased	b. COUNTY	BALT	CMOR	re odmiss E CI	TY	
b. CITY OR TOWN RURAL and give I	(If outside corporate limits,	write	c. LENGTH OF STAY IN	1b	" c. CITY OR TOWN (IF o	utside corpo	rate limits, write RI	URAL and	give nec	rest low	1)	
Sykesvi			5 mths -15	d	ays Baltimore 1					30:4		
	ITAL (If not in hospital, ary	e street d	(ddress)		d. STREET ADDRESS				I		FARM?	
Springfiel	d State Hosp	ita]			817 N. Eutaw Place				YES NO E			
3. NAME OF DECEASED	First		Middle		Lost	4. DATE	Mon	th	Day Year			
(Type or print)	GRACE		WELLMA	N	LOVELL	LOVELL DEATH 2			10		19 60	
5 SEX	6 COLOR OR RACE	MARRI	ED NEVER MARRIED	X B	. DATE OF BIRTH		9. AGE (In years lost bigthday)				ER 24 HRS	
Female	White	MIDOWE	D DIVORCED	⊐ i	9/29/84		75 yrs.	Months	Days	Hours	Min,	
100. USUAL OCCUPAT	ION (Give kind of work do rking life, even if retired)	ne 10b	KIND OF BUSINESS OR	INDUST	RY 11. BIRTHPLACE (Slote	or foreign c	ountry)	12. CI	TIZEN O	F WHAT	COUNTR	
unknown			Prompts		MARYLAN	D		τ	ISA			
3. FATHER'S NAME					14. MOTHER'S MAIDEN N	IAME						
Henry Lym	an Lovell				unkno	WD.						
15. WAS DECEASED EV	ER IN U. S. ARMED FORCE	ES? 16. 5	OCIAL SECURITY NO.	17, 1N	ORMANT		Addr	e33				
no (Yes, no. or unhanoum) (II) yes, give upor or dottes of service) unknown Springfield Hospital Records												
18 CAUSE OF DE	ATH [Enter only one cous	e per lin	e for (o), (b), and (c).]							RVAL BE		
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE [0]	Cor	onary occlu	ssi	on. acute					et and inut		
4 .	DUE TO											
Conditions, if	ony, which) (b)_	Ger	eralized Ar	ter	iosclerosis					Year	q	
gove rise to immediate												
lying cause lost.												
PART II OI		TIONS C	ONTRIBUTING TO DEATH	1 BUT N	NOT RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIY	EN IN PAR	T 1(o) 1	9. WAS	AUTOPSY	
Chronic 200. ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF)	Brain Syndro	me a	ssociated w	ath	senile brai	n dise	n psychot	ac eacti	on	PERFO	RMED?	
200. ACCIDENT W					(Enter noture of injury in f			0000	LOII	,		
OR CONTRIBUTION	G CAUSE OF DEATH											
3 20c. TIME OF INJU	RY Month, Day, Year	20d, IN	JURY OCCURRED 20	e. PLA	CE OF INJURY (Home, form	. 20f. (City	or town)		Countyl		(Stole)	
20c. TIME OF INJU	19	While at work	Not while	Fact	ory, street, office bldg., etc)		·	,,			
	t _ t 1 _ ta d _ d _ t d		9/07	59	10	2/10/6	50					
1 '0	hat I attended the d /10/60	ecease			7.15	A						
alive on2	107.00	, 12	and that a	eath i			n the causes a		he dat			
ACTUAL	Josta de	10	1. Gross 1	11) Soll	MDDRESS (SI	lreet, city or town,	SIGNE)	7	0.	ATE SIGN	
SIGNATURE	permane	100	11111	UF M	0	7/	1 000	- 143	144.	2/	10/6	
PHYSICIAN'S NAME (Type)	Gertrude M.	Gm	ss. M.D.	-	Springfie	ld cta	te Wasni	+ - 7				
220 BURIAL, CREMATIC				nv 00								
REMOVAL (Specify		06	72c NAME OF CEMEN	WY OR	12 12	ZZGLIOCA	JION (City, town, o	or county)	11.	(Stol	e)	
23. FUNERAL DIRECTOR	P'S SIGNATUPE		ADDRESS	ny	Premy f	TA C	7,000	TDAD'S TO	V U-	75		
7	44 41	11	121	1	W	D BYTREGIST	co l					
1 every 1/2	TI FULLINE	11	15 1 hil rech	61	DATE E	EB 154	ري 60	numer &	Tile	u.d		



515

TO HOSPITAL OR ATTENDING PHYSON, The low requires that the death certificate be executed with thours ofter death. Page 4 may be retained by the hospital or ding physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transil permit. Then please remove copart appears. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hour ofter death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

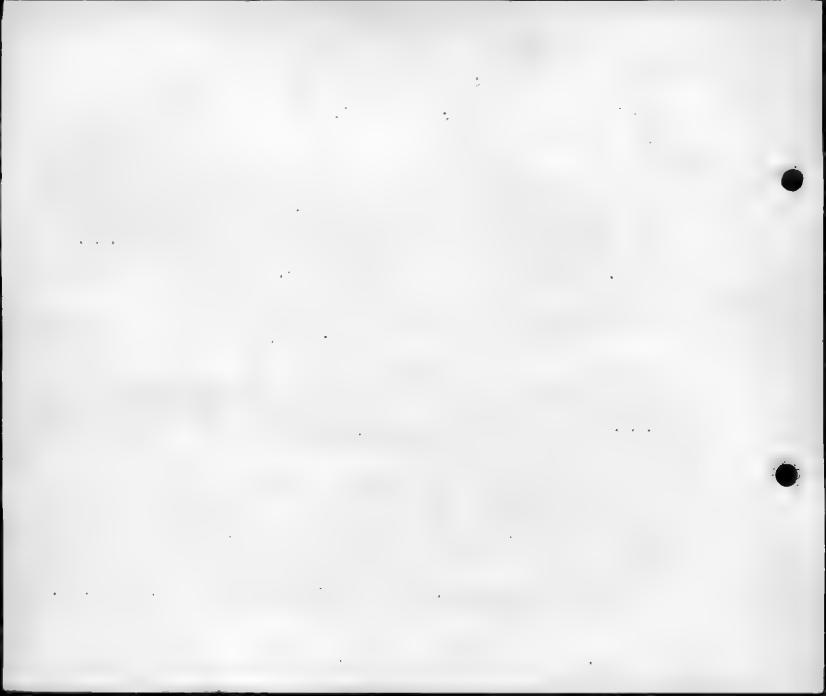
844

CERTIFICATE OF DEATH

1844

01836

				,		17							
PLACE OF DEATH COUNTY Carroll			MARYL	AND	2 USUAL RESIDER O. SJATE Maryla	nce (Wh	ere deceased	fived If institut' b. COUNTY		timore			
b CITY OR TOWN (I RURAL and give no	f outside corporate limi earest town)	its, write	c. LENGTH OF STAY IN	41Ь	c. CITY OR TO	WN (If o	utside corpon	ote limits, write R	URAL and	give nec	prest town	1)	
Sykesvil	le		19Y 8M 1D				Count	y - Spar	ks	add trape y			
OR INSTITUTION	'AL (If nat in haspital, g				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?		FARM?		
	eld_State	Hosp:	ital		None	9					YES [но 🔀	
3. NAME OF DECEASED	Fir		Middle		Last		4. DATE OF	Mor		Do		Year	
(Type or print)		rma				ton	DEATH	Februa:		2	_	1960	
S SEX			RIED NEVER MARRIED	_	B. DATE OF BIRTH	3.0		9 AGE (In years last birthdoy) 60 yrs	Months	Doys	Hours	Min,	
Female	white	WIDOW						120.00					
during most of worl	ON (Give kind of work king life, even if retired	done 10b	KIND OF BUSINESS OR	INDUS	TRY 11. BIRTHPLAC	.t (Stole	or toreign co	untry)				COUNTRY?	
	teacher		quis	New Jersey U.S.A.									
13. FATHER'S NAME								20					
Edwind S.		creo la	COCIAL CECHONIVA LO	T. 2. 48	GLATA IFORMANT	M.	Wyckof	Add					
Yes, no, or unknown)						3 77							
	NO - NONE 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]						Springfield Hospital records						
	ITH [Enter only one co ITH WAS CAUSED BY,					7.6				ONS	ERVAL BE	DEATH	
	IMMEDIATE CAUSE ()C	hronic rhew	mat:	lc heart	115e	8.50			years		3	
416 X	DUE TO	•	1 1 2										
Conditions, if a gove rise to i)	acute systi	tis						weeks		KS.	
couse (a), stating)											
lying couse last.) (c)									0.1046	LI TORCY	
E Socious			CONTRIBUTING TO DEAT	_			MAL DISEASE	CONDITION GIV	VEN NYA	KI I(O)	PERFC	PRMED?	
5 00 46615517144			c reaction,				D 1 51	H =f :t== 10 \			YES 🔼	NO 🗌	
	CAUSE OF DEATH MEDICAL EXAMINER)	206 DE:	SCRIBE HOW INJURY OC	CURKE) (Enter nature of 11	njury in i	roff of Fort	II of item (a)					
20c TIME OF INJUR	Y Month, Day, Ye	Wh le	Not while_		ACE OF INJURY (Hotory, street, office b			or town)		(County)		(State)	
			ork ot work				10 =	•		/ 6			
			ded the deceased f										
	sed olive on Fel	onnar	cy 119 60, and t	hat d	eath occurred	af (3_4;	UM, Africano	the couses ar	id on th	e date			
220 GIGNATURE La hund Tusthan M.D ATTENDING MED STAFF DIRECTOR PHYS D								2,	SIGNED				
22c PHYSICIAN'S NAME (Type)	Edmund Lu	athar	18. M.D.		Sprine		ld Hosi	pital, S	vkesv	ille	. Mo	1.	
230 BURIAL, CREMATIC			23c NAME OF CEMET	EPY O		31.7.		ION (City, town,			~ =====		
REMOVAL (Specify)	1 3 /11/6	0	Green M			ery	B	1	ie, /	lary	lan	1	
24, FUNERAL DIRECTOR	S SIGNATURE		ADDRESS	0			D BY REGISTI	RAR 2Sb. REGI	STRAR'S S	GNATU	RE		
Leonard	J. Ruck	530	5 Harford	Koc	rd #14 o	ATEFE	B 9 '60	a	Ihur S	Human	4		



a. COUNTY Carroll b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL (If not in haspital, give street address) Springfield State Hospital DECEASED

MARYLAND c. LENGTH OF STAY IN 16

Middle

Maryland c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest lawn) Baltimore

Balto_Citv

d. STREET ADDRESS

e. IS RESIDENCE YES NO TO

Year

19 60

Litteston (Type or print) Gertrude 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Famale White WIDOWED [7] DIVORCED |

Matthews B. DATE OF BIRTH January 14

February 9. AGE (In years last birthday) Manths

Manth

2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)

b. COUNTY

IF UNDER 1 YEAR IF UNDER 24 HRS

Virginia 14. MOTHER'S MAIDEN NAME U.S.A.

12. CITIZEN OF WHAT COUNTRY?

PLACE OF DEATH

Frances Valentine

Address

WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO

17 INFORMANI Springfield Hospital Records

1731 N.Charles

DEATH

PART I. DEATH WAS CAUSED BY Rheumatic heart disease with aortic stenosis Conditions, if any, which

DUE TO

Day.

DUE TO

C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.

20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)

YES NO

INTERVAL BETWEEN ONSET AND DEATH

Years

700. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

Nat while at work at work

20e PLACE OF INJURY (Hame, form, factory, street, affice bldg., etc.)

(Caunty)

(State)

ATTENDING M.D. PHYS. 22d. ADDRESS

STAFF PHYS DIRECTOR -

SIGNED

22c HYS CHAN'S

230 SUR AL CREMATION.

REMOVAL (Specify)

Fllis S. Margolin.

Springfield Hospital, Sykesville, Md. 23d. LOCATION (City, Josep, or county)

FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25g. REC'D BY REGISTRAR

arling & thous

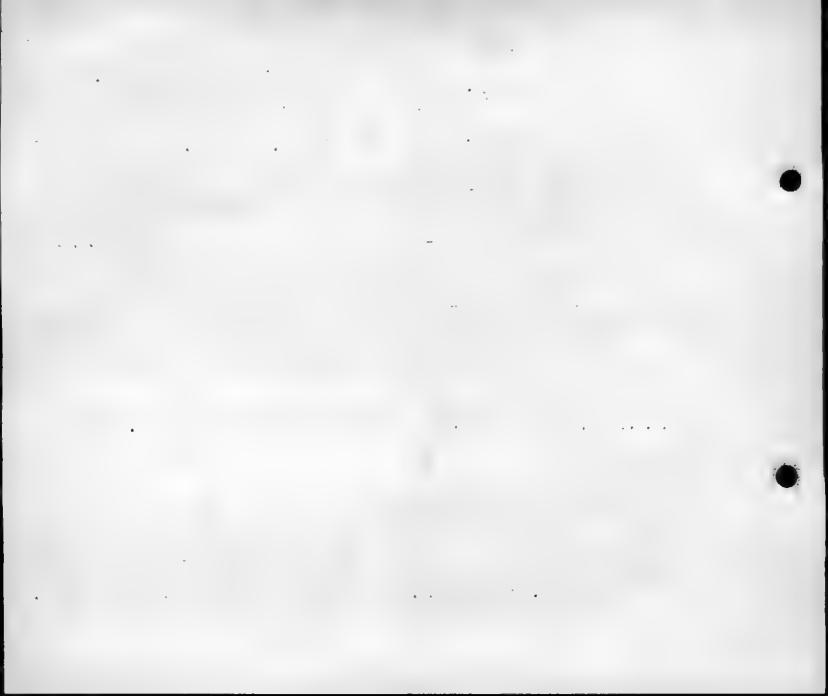
25b, REGISTRAR'S SIGNATURE

After may be retained by the P FUNERAL DIRECTOR: 7 page 3 should be detach 0 VR A15 (4)

ficate

this

S SEX 100 USUAL OCCUPATION (G ve kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) Artist 3. FATHER'S NAME Robert Litteston No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] gave rise to immediate cause (a), stating the underlying couse last. 20c. TIME OF INJURY Hour a.m. 21. I certify that (1) (this haspital) attended the deceased from January 11, 19.60 to February 3, 19.60, that (1) (we) last saw the deceased alive an February 319 60, and that death occurred al.O. 20076m the causes and an the date stated above. 220 SIGNATURE



1. PLACE OF DEATH o. COUNTY

MARYLAND Carroll b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 RURAL and give nearest town] 4yr.7mo.12days Sykesville d NAME OF HOSPITAL (If not in haspital, give street address)

Maryland Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore City

e. IS RESIDENCE ON A FARM? YES NOT

Springfield State Hospital NAME OF DECEASED (Type or print) Margaret

Gertrude 6 COLOR OR RACE 7. MARRIED NEVER MARRIED | B DATE OF BIRTH DIVORCED |

Middle

d. STREET ADDRESS

Miller

DEATH February 9 AGE (In years last birthdoy) Months 85 yrs

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)

1960 IF UNDER 1 YEAR IF UNDER 24 HRS Hours

Year

Female

5 SEX

WIDOWED | White 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired)

August 8, 1874 Maryland

3605 White Avenue

4. DATE

12 CITIZEN OF WHAT COUNTRY?

Housewife

14. MOTHER'S MAIDEN NAME

Charlotte Bartlett

U.S.A.

Days

13. FATHER'S NAME

William S. Bartlett IS. WAS DECEASED EVER IN U. S. ARMED FORCES?

16. SOCIAL SECURITY NO

17 INFORMANT

Address

No

None

18 CAUSE OF DEATH | Enter only one cause per line for (o), (b), and (c).

Springfield Hospital Records

INTERVAL BETWEEN ONSET AND DEATH hours

years

PART I. DEATH WAS CAUSED BY

lying cause lost.

20c. TIME OF INJURY

Hour a.m.

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if ony, which) gove rise to immediate couse (a), stating the underAcute heart failure

Arteriosclerotic cardiovascular disease

DUE TO

PAIR II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY C.B.S. assoc. with circulatory disturbance, 15.01 with cerebral

PERFORMED? YES NO K

200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20d. INJURY OCCURRED Day, Year While Not while

arteriosclerosis, with psychotic reaction.

20e. PLACE OF INJURY (Home, form, 20f (City or town) factory, street, office bldg., etc.)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

(County)

(Stote)

sourthe deceased alive an

MEDI

p. m. 21 I certify that (I) (this haspital) attended the deceased from June 28

of wark of wark

19 55 to February 10 19 60 that (I) (we) last

February 919 60, and that death accurred a5: 104, When the causes and an the date stated above SIGNED

(State)

2/10/60

220 SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Edmund Lusthaus. M.D.

ATTENDING 22d. ADDRESS

PHYS

Springfield State Hospital, Sykesville, Md.

STAFF PHYS.

23d LOCATION (City, fown, or county)

230 BURIAL, CREMAT ON 1 236 DATE THEREOF REMOVAL (Specify) Rurial

/1 2/60

Green Mount, Cem ADDRESS

23c NAME OF CEMETERY OR CREMATORY

Ralto. 25g, REC'D BY REGISTRAR

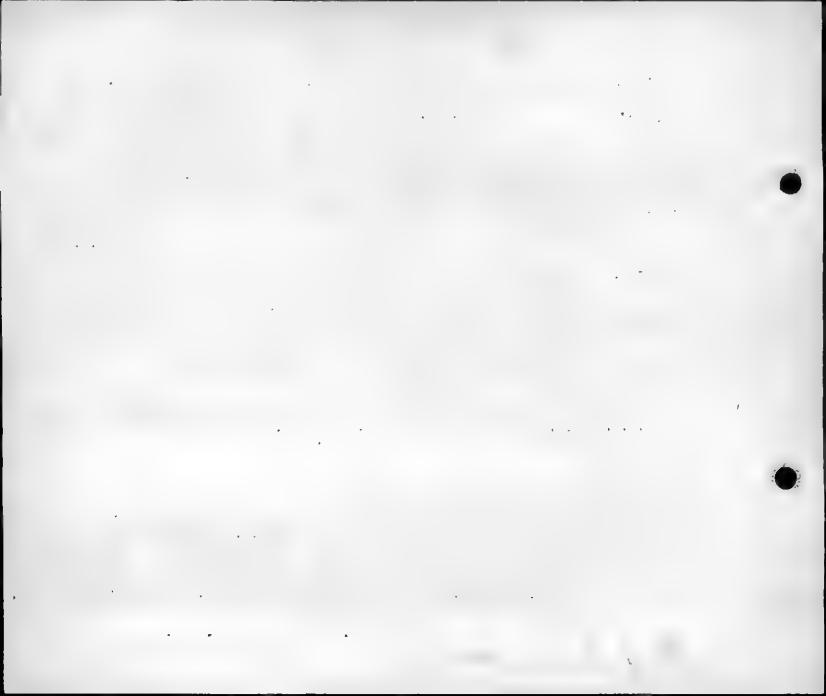
MED DIRECTOR

256 REGISTRAR'S SIGNATURE arthur & Kraus

24 FUNERAL DIRECTOR'S SIGNATURE

VR A15 (4) 1SM 9/59

0 0



CERTIFICATE OF DEATH

A. S.	
-	-
1	
ब	100
<u> </u>	144
8	
亞	

haurs after death. Page 4

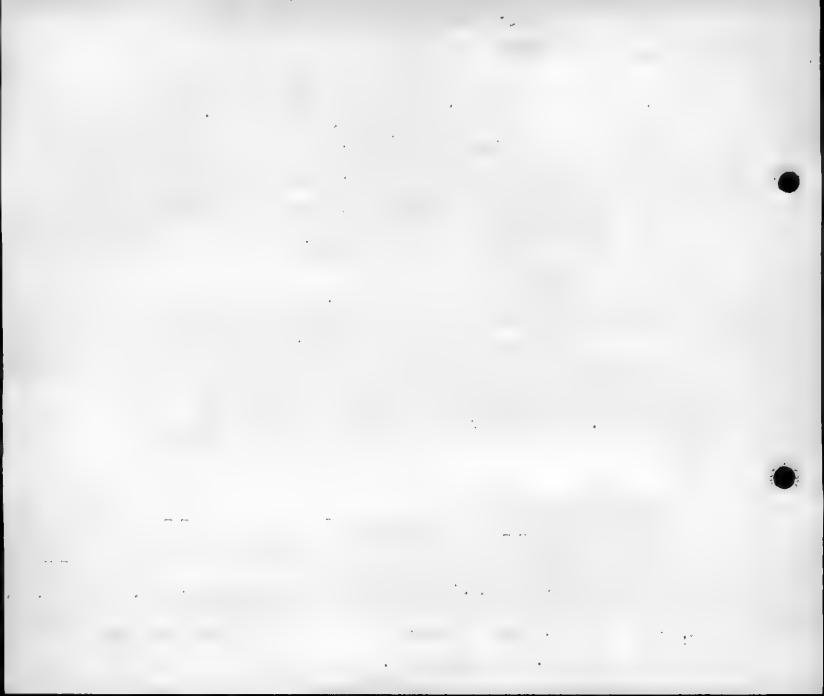
TO FUNERAL DIRECTOR: After this certainate has been signed by the attending physician and completely fulled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AN: The taw requires that the death certificate be executed will

TO HOSPITAL OR ATTENDING PHY

VR A15 (4) 15M 9/59

PLACE OF DEATH		2.	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE 15 common and b. COUNTY									
Car	roll		MARYL	AND	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)							
b. CITY OR TOWN RURAL and give	(If outside corporate limineorest town)	ts, write	c LENGTH OF STAY IN	ч 1ь	c. CITY OR TO	OWN (If o	utside corpo	prata limits, write	RURAL ond	give near	rest lown)
Sykas	ville		14 days				31,	lid.	P3 1 2	1.4		
d NAME OF HOSE OR INSTITUTION	ITAL (If not in hospital, g	ive street a	eddress)		d. STREET ADDRESS e 15 RESIDENC ON A FARM							FARM?
Springfi	eld State H	ospit	al		1617	Lanca	ster	Street			YES 🗌	NO 🗗
3. NAME OF DECEASED	Fic		Middle		Last		4. DATE OF	Mo	nth	Day	y 1	egr .
(Type or print)			(Katie)		illion		DEATH			6		960
5 SEX	6. COLOR OR RACE		ED NEVER MARRIED		ATE OF BIRTH			AGE (In years lost birthday)	Months Months	R 1 YEAR	Hours	R 24 HRS Min
Female_	White	WIDOWE			8-26-1	J-1 /		80 yrs		1 7		
10a USUAL OCCUPAT during most of wo	ON (Give kind of work orking life, even if retired	dane 10b. l	CIND OF BUSINESS OR	INDUSTRY	11. BIRTHPLA	CE (State	or foreign d	country)	12.CI	ITIZEN OF	WHATC	OUNTRY?
						many			US	Nat	ural	ized
13. FATHER'S NAME	**			14	. MOTHER'S							
	Not Know		NC	t Kno								
IS. WAS DECEASED EN	FR IN U.S. ARMED FOR (If yes, give wor or dates of s	MANT	-		Ado	dress						
no unkn Hospital Records												
	EATH [Enter only one co										RVAL BE	
PART ! DI	EATH WAS CAUSED BY. IMMEDIATE CAUSE (o)B	ilateral Br	roncho	pnaumo	nia					ay's	
49/X	DUE TO											
Canditions, if		}										
gave rise to immediate couse (a), stating the under-												
lying couse las	_ ' (c											
<pre>< etasta</pre>	THER SIGNIE CANT CON 100 WITH SE LTIC Carcino	ni le na ma	OLSTU GISES	IH BUT NOT	RELATED TO	THE TERMI	NAL DISEAS	SE CONDIT ON GI	VEN IN PA	RT 1(a) 15	PERFO YES	NO X
THER, NOTIF	VAS UNDERLYING [] IG [] CAUSE OF DEATH Y MEDICAL EXAMINER)	20b DESC	RIBE HOW INJURY OC	CURRED. (E	nter nature of	injury in F	ant I or Po	rt II of item 18.}				
20c TIME OF INJU	10	20d. IN While of work	Nat white	PLACE factory	OF INJURY (F street, office	lome, farm bldg., etc.	20f. (Cit	y or town)		(County)		(State)
21 I certify th	nat (I) (this haspita) attende	ed the deceased f	ram1	-23-	19	60, to_	2-69	19_	60, th	at (I) (i	we) last
	ased alive on 2	- KT	19 <u>.6</u> 0 , and t									
220 SIGNATURE	1 4	1/-	71			r	- Ava-				221	DATE
Con	und of	Lo	wan	M.D	ATTENDING PHYS	ME DI	RECTOR [STAFF Y			2-	LEIGHED.
22c PHYSICIAN'S	3 7 11	* -	100		22d ADDRE							
1011112	dmund Lusth	aus M	• لا•		Spri n	gfiel	d Sta	te Hospi	tal,	Syke	svil	le, L
230 BUR AL, CREMAT REMOVAL (Specif	ON, 236, DATE THEREC		23¢ NAME OF CEMET		EMATORY			TION (City, town,	,		(State	=)
24 FUNERAL DIRECTO	Feb 10, 1	700	Oak Lay	TIT .		25a 0601	Balt	imore M	anyle	and	2F	
	eiler Inc.	1003					EB 1 1					
- C Z	errer. Tuc.	TAOT	Lastern Av	7e.		DAIL		00	Certhur	D. The	and	



burial-transit

the

ding

crematian,

aw requires that the death certificate be executed

CERTIFICATE OF DEATH

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) 1. PLACE OF DEATH o. STATE Maryland a. COUNTY b. COUNTYMontgomery Co. 178 Carroll MARYLAND b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Ken sington 2yrs.3mths.7dys. Svkesville d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS Springfield State Hospital. 1113 Franklin Street YES NO 13 NAME OF DECEASED 4. DATE Middle Month Day Year OF DEATH William John Mock 28 2 1960 (Type or print) 5 SEX 8. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE MARRIED NEVER MARRIED last birthday) Months Days Hours Male White 5-2- 1883 DIVORCED [7] WIDOWED X yrs. 10a USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OF INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Virginia Carpenter-painter 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Bertram William Mock 17, INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Hospital records no INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). QNSET AND DEATH PART | DEATH WAS CAUSED BY: Bronchopneumonia days 49. DUE TO Canditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. B.S. associated with sentile brain disease with psychotic arge infected bed sores CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY CERTIFICATIO Large YES 1 NO T 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Paint of item 18) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f (City or town) (County) (State) Day, Year factory, street, affice bldg, etc.) Hour a.m. While Not while at wark at wark p. m. 102-28-21. I certify that (I) (this hospital) attended the deceased from 11-21-_, that (I) (we) last saw the deceased alive on 2-28and that death occurred at 30M, from the causes and on the date stated above. 220 SIGNATURE 22b DATE 2-28-560ED ATTENDING PHYS MED DIRECTOR STAFF PHYS M.D 28¢ PHYSICHAN'S 22d ADDRESS NAME (Type) Agustin del Campo M.D. Springfield State Hospital Sykeswille, Md. BURIAL, CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county (State) REMOVAL (Specify) 24. FUNERAL DIRECTOR'S SIGNATURE 250 REC'D BY REGISTRAR Colling S. Kraus DATEMAR '60

HOSPITAL OR ATTENDING FUNERAL DIRECTOR: 0 VR A15 (4) 15M 9/59



CENTIFICATE OF DEATH

()	1	8	4	1

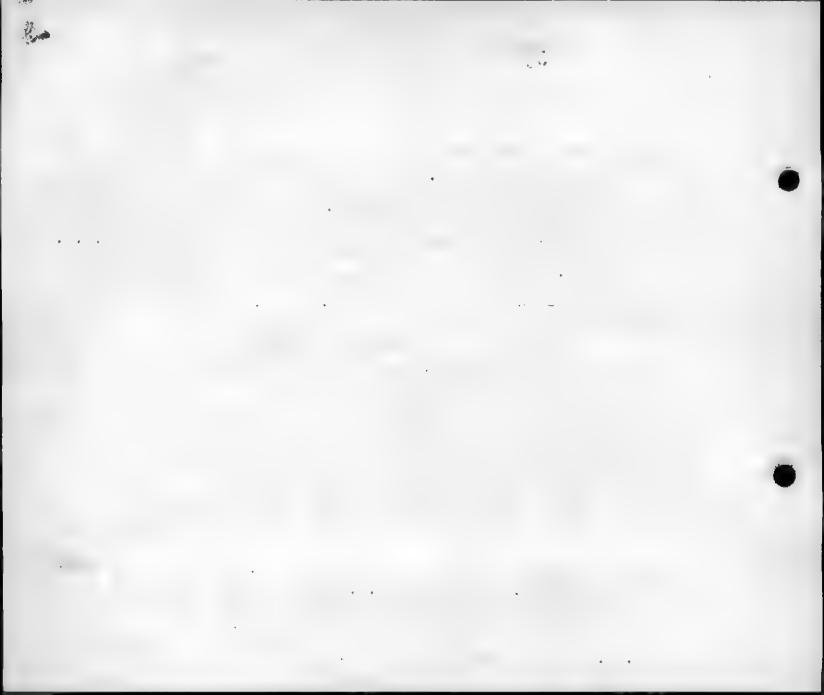
		1849	CERTIFI	CATE OF DEA	ИП			<u> </u>
\	1. PLACE OF DEATH o. COUNTY Carro.	11	MARYLA	II o. STATE	CE (Where deceased I	ived If institution b. COUNTY	n: Residence befo	_
	b. CITY OR TOWN (If auts RURAL and give negrest WOODDIN	town	Life	X Woodb	'N (If outside corporo	te limits, write RU	RAL and give ne	orest town)
	d. NAME OF HOSPITAL (IF			d. STREET ADDI				e. IS RESIDENCE ON A FARM? YES NO
	3 NAME OF DECEASED (Type or print) HA	RRY	Middle A •	MOORE	4. DATE OF DEATH	Mont	h 27,	y Yeor 1960
	36 -	ife a s	MARRIED A NEVER MARRIED OWED DIVORCED		, 1890	AGE (In years last birthday) 9 yrs.	Months Days	Hours Min.
1		ve kind of work done (fe, even if retired)	The same time of	wner Maryl	and	ntry)		S.A.
	13 FATHER'S NAME Harry	L. Moore	e	14 MOTHER'S MA		Benard		
	15 WAS DECEASED EVER IN (Yes, no, or unknown) (If yes,		16. SOCIAL SECURITY NO 213-36-8172	17, INFORMANT	oore, Woo	Addre		and
	PART I. DEATH W	AS CAUSED BY: (EDIATE CAUSE (o) DUE TO (hich) (b)	er line for (a), (b), and (c)] Cardeac ar mplete bee	rest, Corner Corner Clark, G	ary Heron	Moris,	2	1956 7 Jel 60
0	200. ACCIDENT WAS UN	IDERLYING () 20b.	DESCRIBE HOW INJURY OC				EN IN PART 1(a)	PERFORMED YES NO
	-:	lanth, Doy, Year 20	Od. INJURY OCCURRED /hile Nat while work at work	Oe. PLACE OF INJURY (Hon factory, street, office blo		or town)	(Caunty)	(State)
/	21 I certify that (I) saw the deceased 220 SIGNATURE 22c PHYSICIAN'S NAME (Type) HO	(this hospital) at alive an 27 f	tended the deceased fi le 1960, and t - Adll Hall	M.D ATTENDING PHYS. M.D 272d ADDRESS	MEDIRECTOR []	STAFF (d on the date	27 Fel (
		larch 1,19	960 Pine Grov	ve Cemetery	Mt.	ON (City, town, o	Mar	
	24 FUNERAL DIRECTOR'S SIG		ADDRESS Winfield, Ma		REC'D BY REGISTR		TRAR'S SIGNATU	IRE IMA

may be rehained by the hospital of ding physician.

TO FUNERAL DIRECTOR: After this certained has been signed by the ottending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the buriol-transit permit. Then p ease remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to buriol, cremation, ar removal, and in any event, with ja-22 hours after death. N: The low requires that the death certificate be executed with ding physician.

A havrs offer death Page 4

TO HOSPITAL OR ATTENDING PHY VR A15 (4) 15M 9/59

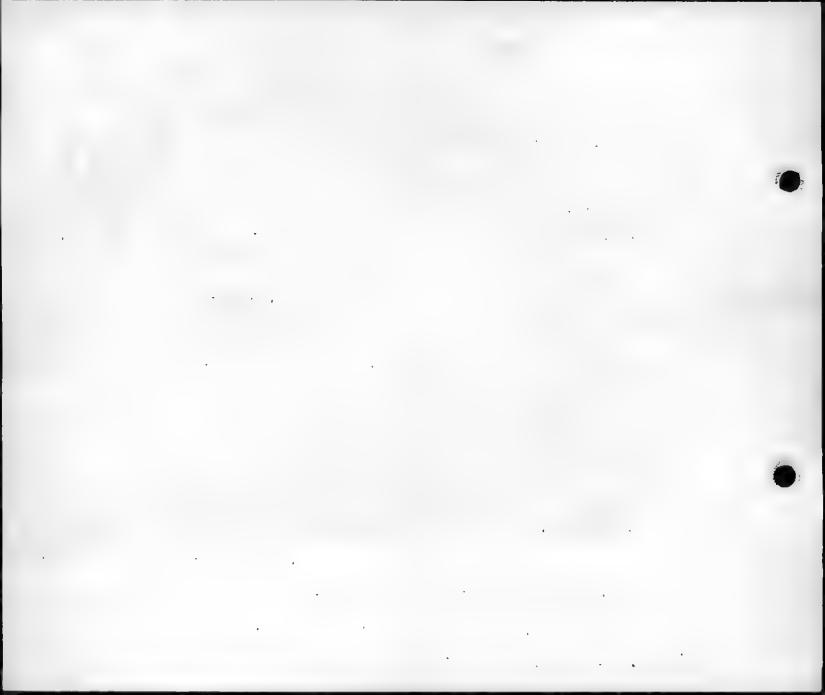


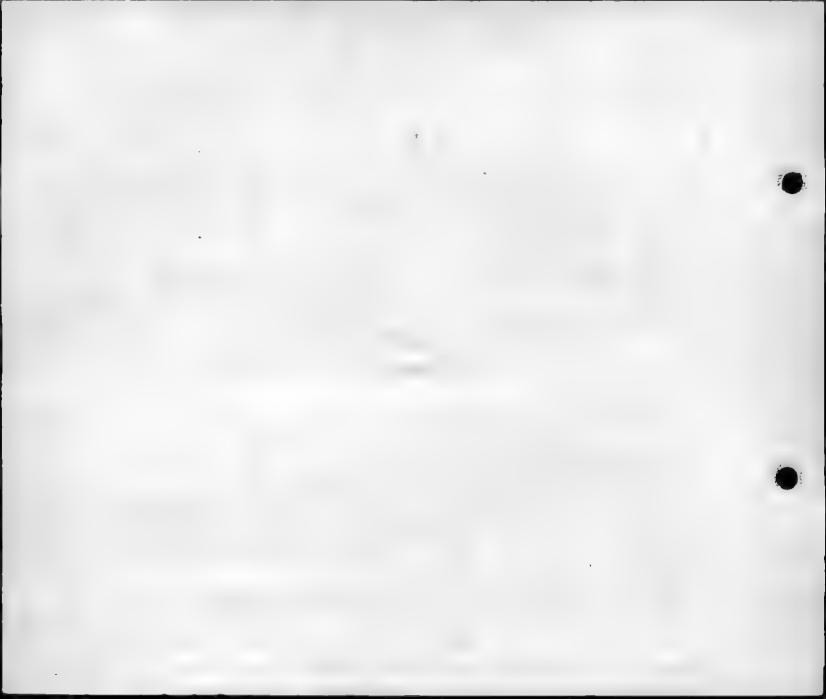
TO HOSPITAL OR ATTENDING PHY

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

			MARY	LAND	STATE DEPARTM	IENT OF HEALTH ATE OF DEATH		18 AORE, 18		0184	
	_	1950 CERTIFICATE OF DEATH Reg. Dist. No.									
		PLACE OF DEATH a. COUNTY	Carroll		MARYLAND	2. USUAL RESIDENCE (Who o STATE Mary)		It COUNTY	Residence befo		
	b. CITY OR TOWN (if outside corporate			its, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If a	utside carporate	imits, write RURA	AL and give ne	arest tawn)	
		RURAL and give nearest town			585 days	Selb;	yville		23	3~ 7	
2	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Henryton State Hospital					d STREET ADDRESS Rout	e 42			e IS RESIDENCE ON A FARM? YES NO	
		NAME OF DECEASED (Type or print)	Fic Is	at aac	Middle	lost Noore	4. DATE OF DEATH	Month Febru	ary 2		
	5. 5	SEX	6 COLOR OR RACE 7. MARR		RIED NEVER MARRIED	B. DATE OF BIRTH	9. A			IF UNDER 24 HRS.	
		Male	Negro WIDOWI			8-26-1889		ost birthday) Months Days Hours Min			
	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR II						or foreign country	y)	12. CITIZEN O	F WHAT COUNTRY?	
		during most of working life, even if retired) Farmer		Snow Hill, Mary		yland	U. S	. A.			
	13.	FATHER'S NAME Isaac Showell			14. MOTHER'S MAIDEN NAME Bell West						
	15. WAS DECEASED EVER IN U. S ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMANT (Yes, no. or unknown) (If yes, give wor or dates of service) 221 - 24 - 9569 Katie Stevenson - Daughter										
Ó			ATH [Enter only one co	ouse per lu	ne for (a), (b), and (c)]				INT	ERVAL BETWEEN	
		PART I, DEATH WAS CAUSED BY: CO. A 24									
		0027									
		Far advanced bilateral cavitary pulmonary Th									
		gove rise la immediate (DISTO									
		couse (a), stating lying couse last.	the under-	P	ulmonary empl	nysema					
	FICATION		HER SIGNIFICANT CON		CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMII	NAL DISEASE CO	NDITION GIVEN	IN PART 1(o)	PERFORMED?	
	CERT	20a ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIF)	AS UNDERLYING DEATH MEDICAL EXAMINER)	206 DES	CRIBE HOW INJURY OCCURRI	ED. (Enter nature of injury in P	ert I or Port II a	fitem 1B)	. 1		
	MEDICAL										
		21 I certify that I attended the deceased from July 15 19 58 to February 2019 60 that I last saw the deceased									
		alive an February 20, 19, 60, and that death accurred at 5:15 AM, from the causes and on the date stated at									
			711	,	6 9		ADDRESS (Street,			DATE SIGNED	
		ACTUAL SIGNATURE/	In line	one	acy M. is.	MD. Fenr	yton, M	aryland		2-20-6	
		PHYSICIAN'S NAME (Type)	dgars M. M	acul	ans, M. D	Fenryto	n State	Hospit	al		
		BUR,AL, CREMATIC REMOVAL (Specify		19/0	22c. NAME OF CEMETERY C			(City, town, or o	county)	(State)	
	23.	FUNERAL DIRECTOR	'S SIGNATURE	100	ADDRESS		D BY REGISTRAR		AR'S SIGNATU	RE	
	-	Colleg &	Mothous	Ell	ratt City	(). //	EB 2 4 '60		ilma 8. Hi		





MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

23 PUNERAL DIRECTOR'S SIGNATURE

01244

24b. REGISTRAR'S SIGNATURE Colling S. Krous

24a. REC'D BY REGISTRAR

DATEFEB 9

	18	51	CERTIFIC	CATE OF DEA	TH		Reg. Di:		TOTA			
1. PLACE OF DI	EATH LTTO11		MARYLAN	2. USUAL RESIDENCE Mary land	(Where deceose	d lived. If instituti b. COUNTY		ce before ad	mission)			
RURAL and	OWN (If outside corporate lind give nearest town) Westminster	nits, write c	30 Years	9,	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) Rural, Westminster							
AD IN CTIT	HOSPITAL (If not in hospital, TUTION STEP, Md. R-1	-		/ d. STREET ADDRESS Westminster	r,Md. R	-1 (Silve	r Run) 01	RESIDENCE N A FARM?			
3. NAME OF First Middle DECEASED (Type or print) Harry Leroy				Myers	4. DATE OF DEATH	2/5/		Day	Yeor			
5. SEX Male	4. COLOR OR RACE White	7. MARRIEI WIDOWED	DIVORCED			9. AGE (In years last birthday) 76 yrs	IF UNDER Months	1 YEAR IF U Days Ho	NDER 24 HRS urs Min.			
during mos	CUPATION (Give kind of world to two kind of working life, even if retire 1 Parmer	done 10b. KI		DUSTRY 11. BIRTHPLACE (S Carrol1			1	S.A.	HAT COUNTRY			
B. FATHER'S N. Pete:	AME r Myers			14. MOTHER'S MAIDE Bmaline		t						
IS WAS DECEA	(If yes, give wor or dotes of	annural l		r informant Ars. Harry L.	Myers,	Westmins		Md. R-	-1			
1 1	OF DEATH [Enter only one of the control of the cont		for (0), (b), and (c).]	Hemo	what	8			L BETWEEN LIND OBATH			
443 Conditio	DUE T		restensus	Cardia-Us	cular	Ulsear	e	10	year			
	stoting the <u>under-</u> but T	(c)	J						I			
PAR PAR PAR PAR PAR PAR PAR PAR PAR PAR	t II. OTHER SIGNIFICANT CO	NDITIONS CO	INTRIBUTING TO DEATH	BUT NOT RELATED TO THE TE	ERMINAL DISEAS	SE CONDITION GIV	EN IN PAR	PE PE	AS AUTOPSY REFORMED?			
	DENT WAS UNDERLYING [] IBUTING [] CAUSE OF DEATH NOTIFY MEDICAL EXAMINER	20b. DESCR	IBE HOW INJURY OCCU	RRED. (Enter nature of injury	in Part I or Fa	rt 11 of item 18.)						
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of work 19 of work of work 19 of work 1								County)	(State)			
ACTUAL SIGNATUR	R.R.	Toll	to MD	M.D. 12 W.K		Street, city or town,		1. Pa	2-6-60			
NAME (Typ		TER	M-D,	12 6	KING.	ST. Li	TTLE	STOU	UN, PF			
220. BURIAL, CI PEMOVAL BULLIA	(Specify)	:OF	22c. NAME OF CEMETER Mt. Carme1			lestown,			Stote)			

Littlestown, Pa.

ADDRESS

DEUNERAL DIRECTOR: After this Commission has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for up 1st the burial-transit permit. Then please remove carbon papers. The stand of 2 should be filled with the registrar prior to burial, crematian, or manaval, and in any event within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed wit may be retained by the haspital or

4 haurs after death. Page 4

K

VS A15 (4) 15M 9/55



dedin. roge +	funeral director,

Filled in by the fu ges I and 2 shoul Poge

offending p Then pieose may be retained by the haspital at Ading physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the page 3 should be detached far use as the burial-transit permit. Then the registrar prior to burial, cremation, ar removal, and in any event

.N: The law requires that the deoth certificate be executed will

TO HOSPITAL OR ATTENDING PHY VS A15 (4) 15M 9/5B

										140 81 011) · · · · · · · · · · · · · · · · · · ·		
	PLACE OF DEAT					o. STATE			ed lived If institut		ce before	odmissi	on)
	Ca	rroll		MAR	(LAND	Ma	ryla	nd	D. COUNT	Carr	011		
1		VN (If outside corporative nearest town)	te limits, write	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							}
	Woodbi			3 m6.		Mt. Airv X							
	d. NAME OF HO	OSPITAL (If not in hosp	ital, give stree	r address)		d. STREET A	DDRESS 7	1			8.	. IS RESI	DENCE FARM?
Weitzel Nursing Home													NO X
3	NAME OF		First	Middle	ŧ	Las	ı	4. DATE	Ma	nih	Day	Y	feor .
(Type or print) MERTIE		L.	P	ENN		OF DEATH	Februar	y	24	. 1	9 60		
5	SEX	6. COLOR OR F	RACE 7. MAI	RIED NEVER MARRI	ED	DATE OF BIRTI	4		9. AGE (In years	IF UNDER		_/	R 24 HRS.
F	'emale	White	WIDOY	VED X DIVORCE	D IM	arch 4	5. 18	80	79 yrs	Months	Doys	Hours	Min.
_				. KIND OF BUSINESS O						12 CITE	ZEN OF 1	WHATC	OUNTRY?
	gnuind west of	working life, even if r ewife	etired)	omestic			_		***				
12	FATHER'S NAM		11	omearic		14. MOTHER'S	rland				J.S.	A .	
13.									_				
_	Willia		snell		1	Sara	in D	uval					
	WAS DECEASED s, no, or unknown)	EVER IN U. S. ARMEL (If yes, gave wor or do		. SOCIAL SECURITY NO		ORMANT	-			ress a fr	7	4	
					Fe:	rris R	. Per	nn, 1	Mt. Alry	, Ma	ryla	ana	
	18 CAUSE OF	DEATH [Enter only o	ne cause per	line for (o), (b), and (c)]	0	-	7	£			TAND	
	PART I.	DEATH WAS CAUSED IMMEDIATE CAU		acino	wa	ofle	wig	e le	eri		Mor	Ha	m 7-6
	171		JE TO			1	1						1
	Canditions	if any, which)	41.4			,							
	gave rise	o immediate	(b) UE TO										
	lying couse	ung me vapur-											
z				CONTRIBUTING TO DE	A TEL DI IT SI	OT DELATED TO	THE TERMS	NIAL PIECA	I F CONDITION OF	UENT INT DAR	T 1(=1/10	M/AC A	LITORCY
CATION	PARI II.	OTHER SIGNIFICANT	COMPITIONS	CONTRIBUTING TO DE	AIH BUI N	OF REDATED TO	INE FERMI	MWF DIREW	SE COMDITION GI	YEN IN PAK		PERFO	RMED?
												YES [NO I
CERTIFI	OR CONTRIBU (IF EITHER, NO	T WAS UNDERLYING TING [] CAUSE OF D TIFY MEDICAL EXAMI	D 20b. DE EATH NER)	SCRIBE HOW INJURY C	CCURRED	(Enter noture o	f injury in P	Port i or Po	rt II of stem 1B)				
Š	20c. TIME OF II	NJURY Month, Doy	Year 20d.	INJURY OCCURRED		E OF INJURY			ly or town)	(0	County)		(Stote)
MEDICAL	Haur o		19 While	Not while	facto	ry, street, affice	bldg , etc.) [
~		. m.			10	- 70		100	100	A			
	21. I certify	y that I attended	the deced	1	4,1	1939	, to	Jec		that I la			
	alive an	yan	2) , 12	(CO , and that	death o	accurred at	7.2. 4.	M, fram	the causes ar	nd an the	date	stated	abave.
		1.17	1	1 .00				ADDRESS (Street, city or lown.	. state)		DATI	E SIGNED
	SIGNATURE	W.C.	lu	ewell	M.	D. 900	50,1	Mai	n 17.		2	2/2	1/60
	PHYSICIAN'S NAME (Type)	W. B. C	ulwell	M.D.		900	So.	Main	St., M	t. Ai	iry,	Md	
220	BURIAL CREM	AT ON, 22b. DATE TI		22c. NAME OF CEM	ETERY OF				ATION (City, town,			(Stote	
	Burial	2-26-	-1960	Winfield			God	Carr		, Mar	פועי	'-	.,
23	*	TOR'S SIGNATURE	1000	ADDRESS	Oli u.	1011 01		D BY REGIS	E .	STRAR'S SIC	70'		
20.			Minfie	ld. Mary	end			B 2 9		rthur S.			
	C. M.	ا و د الكالد اللحاداة	LITTYTIC	Lug mary	CULTU		DATE 1 16			,			



or remayal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01848

-1	_		1050							Reg. Dis	ir. No.		
		LACE OF DEATH	2000				2. USUAL RESIDENCE (Where deceased lived. If Institutions Residence before admission)						
	C	COUNTY	arroll			MARYLAND	o. STATE Maryland b. COUNTY Baltimore						
	Ь	. CITY OR TOWN (If a	utude corporate limits, writ	# RURAL	c. LENGTH OF	STAY IN 1b	c. CITY OR TOWN (I		porote limits, write				wn)
1	5	Sykesville			30yrs.11	mos 6d	vs Cocke	vsvill	le	_ >			
. [d	I. NAME OF HOSPITA	L OR INSTITUTION (If not in he			d. STREET ADDRESS						ESIDENCE A FARM?
	, C	Springfiel	d State Ho	sni t	1		None						NO 🔯
I	3. [NAME OF DECEASED	Fir	st	Midd	le	Last	4. DATE	Month)	Day	Y	(ear
1		Type or print)	Cath	erine	B.	H	emmells	OF DEATH	Febru	ary	3.	1	9 60
I	5. S		6. COLOR OR RACE	7. MARR	HED NEVER MA	RRIED 2 8.	DATE OF BIRTH		9. AGE (In years	IF UNDER 1			ER 24 HRS.
1		Female	White	WIDOW	Transfer Tra		19907 2-26-		XXX 58yrs.	Months D	Doys	Hours	Min.
ı	10a.	. USUAL OCCUPATION	N (Give kind of work	done 10b.	KIND OF BUSINES	S OR INDUSTR	Y 11. BIRTHPLACE (Stote	or foreign	country)	12. CITIZ	EN OF	WHAT	COUNTRY
ı		Housework	me, even ir remocj		***		Maryland			U	S.	A.	
I	13.	FATHER'S NAME					14. MOTHER'S MAIDEN						
		Daniel Re	mmells				Emma Tho	mpson					
1	15.	WAS DECEASED EVE	R IN U. S. ARMED FO	RCES? 16	. SOCIAL SECURITY	NO. 17. IN	FORMANT		Address				
		No	he have fine were on equal or		-	Sp	ringfield H	ospita	1 Records	8			
Ī		18. CAUSE OF DEAT	H [Enter only one can	se per line	o for (o), (b), and (c					10-11-11-11-11-11-11-11-11-11-11-11-11-1	INTERV	VAL BETWE	FEN
ı		PART I. DEATH	WAS CAUSED BY:	Pr	lmonary	edema a	ind bronchop	neumoi	nia		-	NS	1160
ı		260×	OUE TO										
ı		Conditions, if an	y, which) (b)	H	yperglyce	mic cor	na				Da	ys	
ı		gove rise to immediate couse (c), stating the underlying DUE To Thrombophlebitis of the right ileac vein Days											
ı		couse lost.	(c)	1.1	итошпорит	edivis	or the righ	r TTes	ac vern		Da	lys	
I	8	Epilepsy with mental deficiency. Fracture, neck of right femur.											
I	3	rbrrebsy (wron wenca	T der	iclency.	racuu	re, neck of	right	remur.		Y	ES 🔀	NO 🗍
ı	CERTIFICATION	200. EXTERNAL CAUS	SE WAS	b. DESCRI	BE HOW INJURY O	CCURRED. (En	ter nature of injury in Po	rt I er Port II	of item 18.)				
		CAUSE OF DEATH.	. KIDOIII G	Patie	ent was fo	ound ly	ing on floor	r.					
1	MEDICAL	20c. TIME OF INJURY	Month, Day, Ye			D 20e. PLACI	E OF INJURY (Home, forry, street, affice bldg., etc	n. 20f. (Cit)	y or town)	{Сооп	ily)		(Stote)
ı	WED	9:30 C.M.	1/26/19	60 Whi	le Not while of work d	0.0	nital	Syke	sville	Carr	oll		Md.
1		21. I certify the	at I taak charge	af the	remains descr	ibed abay	e, held an Autops	у [Х], І	nspection X.	Inquiry	凮.	and	find that
		A	from: Natural			/	ide 🗍, Homicide	_	ndetermined c	_			
		()		en 1		_/							
		ACTUAL	ances.	Τ,	Mars		M.D. CHIEF MEDICAL E	XAMINER [DATE S	IGNED
ı			7	-			ASSISTANT MEDIC	AL EXAMINE	ER 🔲		2	/4/6	'n
"		EXAMINER'S James T. Marsh, M.D. DEPUTY MEDICAL EXAMINER W									2/	4/0	O
İ	220	BURIAL CREMATION	, 226. DATE THEREC)F	22c. NAME OF C	EMETERY OR C	REMATORY	22d. LOCA	TION (City, town, o	or county)		(State	0)
	B	REMOVAL (Specify)	2-6-196	0	Poplar	Grove	e Cemetery	5				Md	
	23.	FUNERAL DIRECTOR'S	SIGNATURE		ADDRESS			D BY REGIST	 	TRAR'S SIGN	NATURI	E	
		Brooks F	uneral S	ervi	ce Tow	son 4.	Md DATEFE	B 8 '8	60 Cia	June 8 1	for	4	

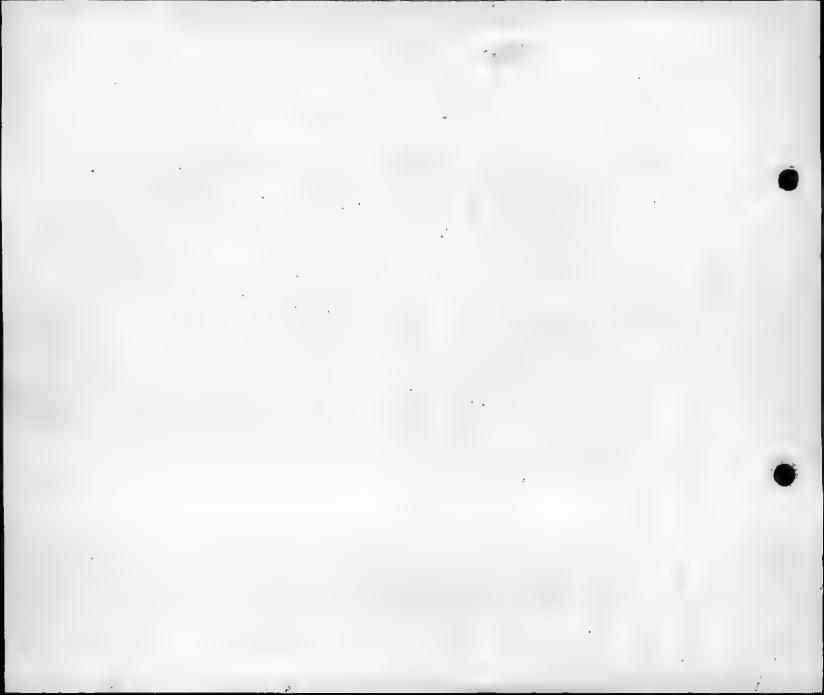


VR A15 (4) 15M 9/59

M

01847

\vdash		
1	PLACE OF DEATH o. COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before odmission) b. COUNTY
	b CITY OR TOWN (if autside corporale limits, write NURAL and give nearest tawn)	c. CITY OR TOWN (If autiside carporate limits, write RURAL and give nearest town)
	G. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d STREET ADDRESS . Historielle e. is residence on a FARM? YES \(\) NO
3.	NAME OF DECEASED (Type or print) FLLL EN PEACE A	EYNOWDS 4. DATE Month Day Year 1960
	WIDOWED DIVORCED	A DATE OF BIRTH PAGE (In years lost birthday) Months Days Hours Min
L	c. USUAL OCCUPATION (Give kind of work dane during most of working life even if retired)	ma. 7. S. A.
13	John T. Allfander	Outlevie Belt
	WAS DECEASED EVER IN 6 S ARMED FORCES? 16 SOCIAL SECURITY NO 17 16 es no or unknown; (If yes, give wor of dates of service) 17-/2-2776	Mr Allaw H. Reynolder Exylumille, ruck
	PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Can dia : Vaile	we, Corney Rosenloses, Onset and Death
1	Conditions, if any, which) (b) Cirlerior Cleracis	murolyel. He herteun to
	gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Influence (c)	17 Feb bo
STATION		NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO
I CERTIFI		D. (Enter nature of injury in Part I or Part II of item 18.)
MFDICAL	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 40 PL While Not while 19 of wark 10 at wark 10 to	ACE OF INJURY (Hame, farm, 20f. (City or tawn) (County) (State) clary, street, affice bldg., etc.)
	21. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on	15 56 19, to 12 tell 19 (I) (we) lost deoth accurred of ////M, from the causes and on the date stoted abave.
	220 SIGNATURE & Hall is	M.D. ATTENDING MED STAFF 226 DATE S GNED PHYS. DIRECTOR PHYS. 2-13-60
	22c PHYSICIAN'S NAME (Type) HOMARD E. HALK	22d. ADDRESS Affresville, Md 177460
	BURIAL CREMATION 236 DATE THEREOF 236 NAME OF CEMETERY CONTROL (Specify) 2-26-66 (MILAN)	Maple, Such, the Bullet to mit
2.	EUNERAL DIRECTOR'S SIGNATURE ADDRESS AUTHORITIES ADDRESS ADDRESS ADDRESS	250 RECK BY REGISTRAR 256. REGISTRAR'S SIGNATURE CITIZEN S. THANK



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Can	1055 CERTIFICATE OF DEATH									
M	c	LACE OF DEATH COUNTY A STATE MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE b COUNTY							
^	1	CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 PRURAL and give negrest town) I. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d STREET ADDRESS e. IS RESIDENC ON A FARM YES NO							
		IAME OF RECEASED Type or print) ROSIE LEE RH	121 Bette M 4. DATE Month Day Year OF DEATH FIELD 9 196							
2	6	6 COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR IND	Jun. 13, 1882 Tost Dirthday) Months Days Hours Min							
		during most of working life, even if retired) ATHER'S NAME	14. MOTHER'S MAIDEN NAME							
	15	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	MERGANIA CACCETY Address.							
,	[Yas	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]	interval Bersey - who there when I was							
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulling in a Conditions, if ony, which gave rise to immediate couse (a), stoling the under- lying cause lost. (b) If the interval in the couse (c)	uny Edema. 48 hors it failure mounts un sin Unteric Schessin years							
,m	FICATION		UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOP PERFORMED? YES NO RED (Enter nature of injury in Part I or Part II of item 18.)							
	IL CERT	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
	MEDICAL		PLACE OF INJURY (Home, farm, 20f (City or town) (County) (Skifoctory, street, office bldg., etc.)							
		27 I certify that (1) (this hospital) attended the deceased from saw the deceased alive an Feb 8 1960, and that 220 SIGNATURE Carry CM- Francisco	death accurred of PM, from the causes and an the date stated aba ATTENDING DIRECTOR STAFF PHYS PHYS SIGN							
1		Page (Type) Aui Chut Ma.	22d. ADDRESS SIKE SILK MD							
14	Ž	BURIAL CREMATION, 236 DATE THEREOF 236 NAME OF CEMETERY DEMOVA. (Specify) 2.11 6 6 Ditely	Tick Controlle, Will.							
	24.	FUNERAL DIRECTOR'S S GNATURE ADDRESS	750 RECID BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHY may be retained by the hospital at VR A1S (4) 1SM 9/59

I hours after death. Page 4

The law requires that the death certificate be executed withing physician.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

73	1	0	- 4	0
()	عات	3	士	.1

havrs after death. Page 4

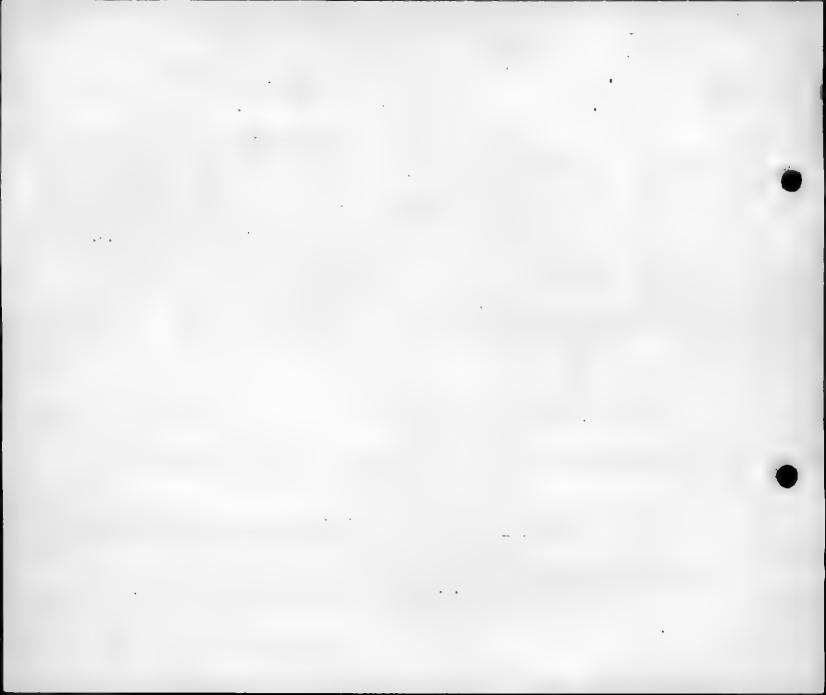
may be retained by the haspital or "ding physician.

TO FUNERAL DIRECTOR: After this cert ficate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be discovered for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be discovered for use as the burial-transit permit, and all of the prior is belief.

AN: The law requires that the death certificate be executed with

TO HOSPITAL OR ATTENDING PHYS VR A15 (4) 15M 9/59

18	SE CERTIFIC	CAT	E OF DEATH					
1 PLACE OF DEATH 6. COUNTY Carroll	MARYLA		2. USUAL RESIDENCE (Who state Larylar		d lived. If institution b COUNTY	n Residence	before adm	ission)
b. CITY OR TOWN (if outside corporate limits, v RURAL and give nearest town) Sykesville	write c. LENGTH OF STAY IN 15 yrslim2 d		e. city or town (if or Baltimore		rote limits, write RU		ve negrest to	wn)
d. NAME OF HOSPITAL (If not in hospitol, give of NSIUUTION. Sprin field State Ho	street oddress) ospital		d. STREET ADDRESS 2140 Boyd	Stree	t	•	ON	A FARM?
3. NAME OF First DECEASED (Type or print) George	Middle E		Riley	4. DATE OF DEATH	Mont 2		Day 7	Yeor 1960
37 . 7	MARRIED NEVER MARRIED		8-19-01		9 AGE (In years lost birthday) 50 yrs.		YEAR IF UN Days Hour	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	e 10b KIND OF BUSINESS OR I	NDUST	West Vi		* *		S.A.	COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN N	IAME				
Harman A, Riley		ĺ	Katheri	ne Mo	ran			
15 WAS DECEASED EVER IN U. S. ARMED FORCES [Yes, no, or unknown] (If yes, give wor or dates of service)			ormant Hospital Reco	ords	Addre	P1.5		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse last. (c)	Arteriosclerot						year	
PS CHOSES WITH CHOSE 200 ACCIDENT WAS UNDERLYING D 201	b. DESCRIBE HOW INJURY OCC					IN IN PARI		ORMED?
200 ACCIDENT WAS UNDERLYING 1 20% OR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	or bestinge (101) highli occ	OKKED	truck inside of infort we		, , , , , , , , , , , , , , , , , , , ,			
20c TIME OF INJURY Month, Doy, Year Hour o. m.	20d. INJURY OCCJRRED 20 While Not while of work of work		E OF INJURY (Home, form ry, street, office bldg., etc.		or town)	(Ca	ounty)	(Stote)
21 I certify that (I) (this haspital) of says the deceased alive on	A A		attending ME	AR. From	*		date state	
22c. PHYSICIAN'S NAME (Type) Edmund Lust	thans M.D.		22d. ADDRESS Springfie]	ld Sta	te Hospit	al,Sy	kesvil	
230 BURIAL CREMATION, 236 DATE THEREOF REMOVAL (Specify)	23c NAME OF CEMETE	1	CREMATORY	230 LOCA	TION (City, lown o	ct () M	tole)
24. FUNERAL DIRECTOR'S SIGNATURE	& Kerrylin K	no H	CHINA SI DALE			TRAR'S SIGN		



2. USUAL RESIDENCE (Where deceased lived. If Institutions Residence before admission) PLACE OF DEATH g. COUNTY MARYLAND b. CITY OR TOWN of outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) M. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO P NAME OF DATE **First** Middle Doy Lost Month Yeor OF DEATH (Type or print) 19/6 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED THEVER MARRIED 1 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS Months Hours WIDOWED | DIVORCED [yes 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAÎDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANI 16. SOCIAL SECURITY NO. If yes, give war or dates of services INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH Enter only one couse per line for (o), (b), and (c). PART I. DEATH WAS CAUSED BY 422 IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise la Immediale cause **DUE TO** (a), stating the underlying couse last. PART IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D. SEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS PERFORMED? NO 20g, EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Stole) 20f. (City or Jown) (County) factory, street, affice bldg., etc.) While p. m. Not while at work p.m. at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry and find that death resulted from: Natural causes Accident . Suicide . Homicide , Undetermined cause DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (State) REMOVAL (Specify) ADDRESS FUNERAL DIRECTOR'S SIGNATURE 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

47 & Maria

forworded to the Chief O FUNERAL DIRECTOR: VS. A15ME(5) 5M 9/55

DEPUTY MEDICAL EXAMINER

should be cremotion,

> 5 c puo

may



e. IS RESIDENCE

INTERVAL BETWEEN

ONSET AND DEATH

onths.

Years

Years

25b, REGISTRAR'S SIGNATURE

25a REC'D BY REGISTRAR FEB 1 2 '60

DATE

PERFORMED? ___

YES NO P

(State)

ON A FARM?

YES NO F

Year

19.0

1858 CERTIFICATE OF DEATH

et lik	1
)
	/

with director

be filed

ploops

funeral

015

25 death

i i completely filled Pages papers. carban remave please permit **burial-transit**

and physician altending signed been ote TO HOSPITAL OR ATTENDING PI may be retained by the haspital TO FUNERAL DIRECTOR: After this page 3 shauld be detached for a page 3 shauld be the State Board of 9

VR A15 (4)

15M 9/59

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission a. COUNTY b. COUNTY l'arvland Carroll MARYLAND Frederick c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Cmos . Didays kesville LeGore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Springfield State Hospital None NAME OF DECEASED Middle 4. DATE Lost Month (Type or print) 17 (A) (A) (A) Silas Clayton Schildt. DEATH February 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthday) Months inle ...hi te DIVORCED X WIDOWED [* yes 10a USJAL OCCUPATION (Give kind of work done 10b K.N., OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Lime Pla-nt Laborer Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME xxxxxxxx David W. Schildt Elizabeth Jones XXXXXXX IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Springfield Hospital No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)_ Gangrene of right foot **DUE TO** Conditions, if any, which Peripheral arteriosclerosis gove rise to immediate **DUE TO** couse (a), stating the under-Generalized arteriosch rosis. lying couse lost. PART HOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY S.assoc.with cerebral arter osclerosis with psychotic reaction, lus alcoholism 200. ACC DENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. 20s. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) Year 20d. INJURY OCCURRED (County) factory, street, office bldg , etc.) Hour a.m. While Nat while at work of work 21. I certify that (I) (this haspital) attended the deceased from July 24, 1959, to February 8, 1960, that (I) (we) last saw the deceased alive an Teornary £19 60, and that death accurred a PNI M, from the causes and on the date stated above. 22a. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. M.D. PHYS 22c PHISIC AN'S 22d ADDRESS Oprin field Tospital, Sykesville, Id. Agustin del Carro. 23g B' FIAL CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, tawn, or county) Church of Brethern Cem. Rocky Ridge, Feed.

ADDRESS

Thurmont.



age 4	sclar,	#		H	
, Pc	l dire	12 ed.	-	-	-
death	nerd	e P			
Fler	the fi	shaul			
o Suns	by	d 2		7	/
t ho	led in	_ o	į		
	JE E	oges	deat		
w b	plete	rrs.	ofter		
ecute	com	pope	OULS		
De ex	and	rpou	2		
a lo	sicion	e co	rithin	-	
ertifi	phy	'ema	100		
ath o	nding	Sase	ny e	4	77.0
e de	atte	ld na	in Q		
t tor	y the	The	ond ,		
res H	ed b	ermit.	the State Board of Health prior to burial, cremation, or removal, and in any exact, within 72 hours after death.		
redu	an. 1 sigr	si p	or rer		
MO.	i beer	l-tran	ian, (
The	ng pi e has	burio	emot		
Ÿ.	rricat fricat	the	ما, در		
Į.	o Cerr	00	pour r		
1 S	P 10	far u	ior to		
NO.	Phas Afte	ched	발		
ATTE	Ç Z	deto	Hed		
8	ned b	d be	ind of		
ITAL	ZAL [shall	e Bod		
250	o pe	1000 O	Shat		
10 H	TO F	pd	the		
TO HOSPITAL OR ATTENDING PHY No. The law requires that the death certificate be executed will haurs after death. Page 4	may be retained by the haspital of the function of the control of the function and campletely filled in by the funeral director.	(4)			

	8	1.5	250	CERTIFIC	AIL	OF DEAT	Н					
	PLACE OF DEATH	rroll	, 0 3	MARYLANI		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Prince Goorges						
	b CITY OR TOWN (II RURAL and give ne	autside carporate limi arest town)	ls, write	c. LENGTH OF STAY IN II		c CITY OR TOWN (rate timits write R	URAL and	give nearest	fawn)	
-	d. NAME OF HOSPIT	AL (If not in hospital, g			5	d. STREET ADDRESS			1 -17-		S RESIDENCE	
-		1.1 State He				Illy ledis					ES NO	
	3. NAME OF DECEASED (Type or print) Connad		_	Middle Draw		Shafer	4. DATE OF DEATH	Month February		Day	19 60	
5	5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED					ot. 27, 19		9 AGE (In years lost birthdoy) yrs	Months Months		UNDER 24 HR aurs Min	
100	USUAL OCCUPATION OF WORK SCIVICE	N (Give kind of work log life, even if retired	done 10b	KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (SM		ountry)	12. CIT	ZEN OF W	HAT COUNTR	
13. FATHER'S NAME Tranklin Shafer 14. MOTHER'S MAIDEN NAME Lattie B. Young												
15 (Ye		R IN U. S. ARMED FOR If yes, give war or dates of s		None	Sor	mant im-Piold:	To sui tel	Add conds				
	PART I. DEA 420. I Canditians, if or gave rise to it cause (a), stating tying cause last,	nmediate ()	cute myocardi coronary arten ulmonary eder	rios		2			Ye Ho	ars urs	
CATION		Praecox	DITIONS	CONTRIBUTING TO DEATH	BUT NO	RELATED TO THE TE	RMINAL DISEAS	E CONDITION GIV	PEN IN PAI	1	WAS AUTOPS PERFORMED? ES TO NO	
CAL CERTIF	200 ACC DENT WA OR CONTRIBUTING (IF EITHER, NOTIFY 20c. TIME OF INJUR	S JNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) Y Manth, Doy, Ye		CRIBE HOW INJURY OCCUR		of INJURY (Home, f				County)	(Sta	
MEDIC	Hour e.m.	19	While of wor	Not while	foctory	, street, affice bldg.,	etc.)	,				
	21. I certify that (I) (this haspital) attended the deceased fram CC volume 20, 1951, ta Peb. 7, 1960, that (I) (we) la saw the deceased give an 20, and that death accurred of 21 ATTENDING MED STAFF 22b DATE SIGNATURE											
234	22c PHYSICIAN'S NAME (Type)	Edmund Lu		US, I'.D.	M.D.	PHYS. D	23d LOCA	STAFF PHYS 2	ar county)	٠٠٦٠,	(Stote)	
	REMOVAL (Specify) Burial	2- 11-19		Mt. Olivet		metery	Fre	ederick-	Mary]		(31016)	
24	FUNERAL DIRECTOR'	S SIGNATURE VV	H	ADDRESS Frederic	ak-		PER 1 5 '6		STRAR'S SI	GNATURE		



DEPUTY MEDICAL EXAMINER



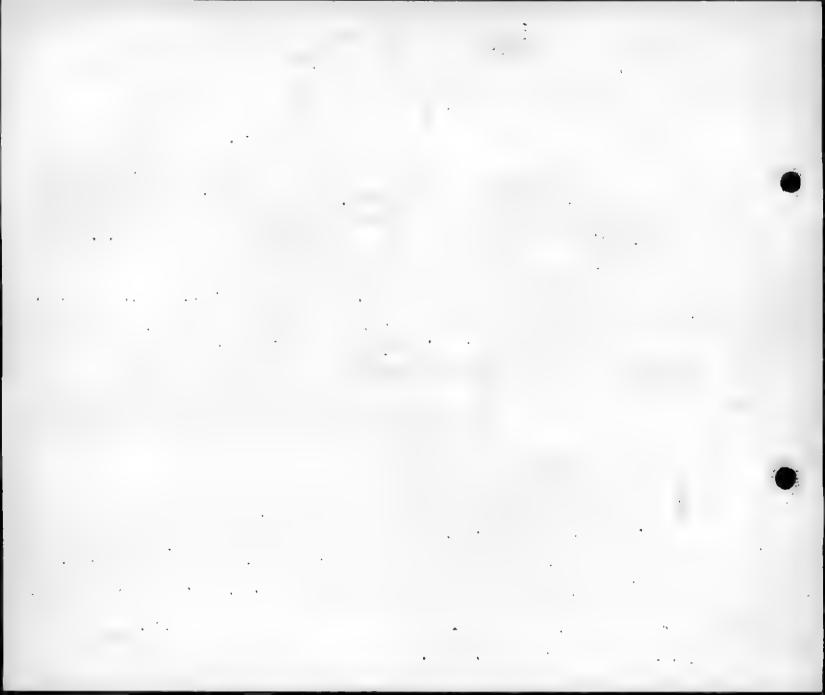
T

	Key, Dist. 140.						
1. PLACE OF DEATH 1861	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
Carroll MARYLAND	o. STATEMARYLAND b. COUNTY Carroll						
b. CITY OR TOWN (If autifide corporate limits, write RURAL and give nearest fown)	c. CITY OR TOWN (If outside corporate timits, write RURAL and give nearest town)						
Westminster RURAL 2 yrs.	XWestminster RURAL						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?						
Route # 140	R.D.#2 YES□ NO 🗖						
3. NAME OF First Middle DECEASED (Type of printlEDGAR (EDWARD) SUTHAL	RD 4. DATE Month Doy Year PEATH Feburary 8 1960						
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 38	DATE OF BIRTH 9. AGE (in yours IF UNDER TYEAR IF UNDER 24 HRS.						
Male White WIDOWED DIVORCED []	June 18, 1916 43 yrs. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUST							
during most of working life, even if retired) Laborer Nursery	Virginia U.S.A.						
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Elisah Suthard	Estell Heflin						
(Yes, no. as welcowed) I III was nive were as dates of services	NFORMANT Address						
218-128352 Lal	ura Smith Suthard, Westminster, MaD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETÄGEN OMSET AND DEMM -						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE	- OL SKULL -						
1/6X DUETO							
Conditions, if any, which by							
gave rise to immediate cause (a), stating the underlying DUE TO							
cause last. (c)							
	IOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO YES NO YES						
200. EXTERNAL CAUSE WAS PRIMARY FLOR CONTRIBUTING DI CAUSE OF DEATH.	nter nature of injury in Part I or Part II of item 18.)						
	custumy - collision						
TELL Manual Control of the Control o	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ory, street, office bldg., etc.)						
6 1960 of work of work Rest							
21. I certify that I took charge of the remains described abo	ve, held on Autopsy						
death resulted from: Natural couses . Accident . Suid	cide 🔲, Homicide 🔲, Undetermined cause 🔲.						
1 5/1	DATE SIGNED						
SIGNATURE SHILLS J. Mine L	CHIEF MEDICAL EXAMINER						
EXAMINER'S T. MARS T. DEPUTY MEDICAL EXAMINER DEPUTY DEPUT							
220. BURIAN CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR	CREMATORY 22d. LOCATION (City, town, or county) (State)						
Buris Feb. 11,1900 Prospect Hi	11 Cemetery York Penna.						
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE						
C.M. Waltz, Winfield, Maryland	DATE FEB 1.1 '60 Ciriling S. Fliance						

VS. A15ME(5) 5M 9/55



15M 9/58



VR A1S (4) 1SM 9/59

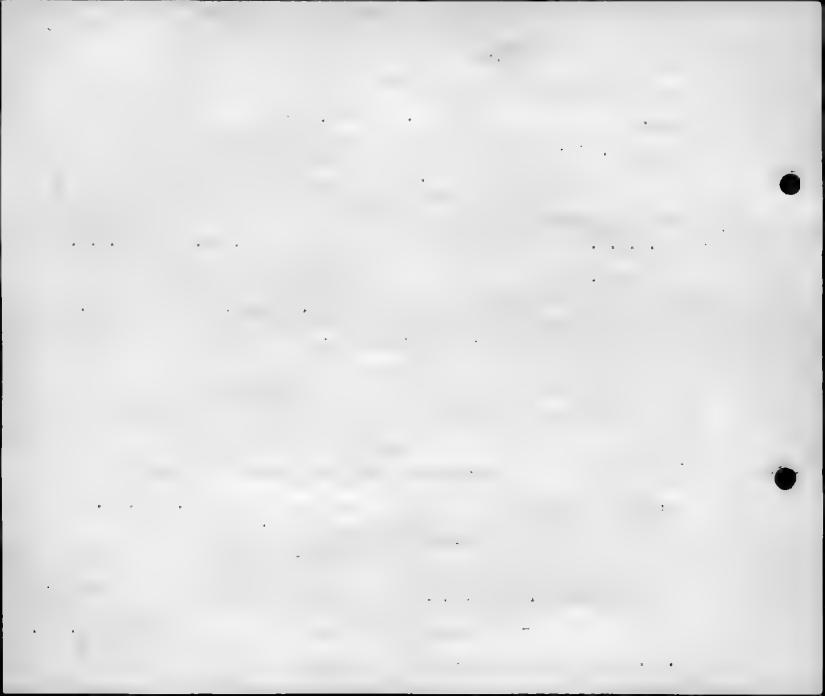
015 Then please remaye carbon popera.

			863	CERI	IFICA	TE OF DE	A 111						
1.	PLACE OF DEATH o. COUNTY	arroll		м	ARYLAND		ence (wh Maryl		d lived. If institut b. COUNTY			e odmiss	ion)
	RURAL and give no		ts, write	c. LENGTH OF S					rote limits, write l	URAL ond	give nea	rest town	1]
H	d. NAME OF HOSPIT	TAL (If not in hospital, g	jive street	3yrs.9m	08.24C	d. STREET A		eposi	C .			e. IS RES	IDENCE
	OR INSTITUTION	field State				No	ne						NO DO
3	NAME OF DECEASED	Fir		-	ddle	lost		4. DATE OF	Мо	nth	Do	γ .	Year
L	(Type or print)	Rober	rt			Taylor		DEATH	Febr		19	2	19 60
S.	SEX	6. COLOR OR RACE	1	RIED NEVER MA		B. DATE OF BIRTH	1		9. AGE (In years lost birthdoy)	Months Months	ER 1 YEAR Days	Hours	ER 24 HRS. Min
10	Male	White	WIDOW		RCED [1931	A CE ICana	na finadas a	28 yrs	12.0	ITIZEN OF	WHAT	COUNTRY
100	during most of worl	ON (Give kind of work king life, even if retired	dane IUb.	KIND OF BUSINES	IS OK INDU			_	ountry)	12.0			,OONIKII
12	N ONE			enb		14. MOTHER'S	yland				U.S.	H. e	
13.	_	m7						A PARIL					
15		Taylor R IN U. S. ARMED FOR	CES2 14	SOCIAL SECURITY	NO 17 I	OUK	nown		Ado	ress			
[Yı		(If yes, give wor or dotes of s		_		Springfie	1d Ho	enite					
-	-	ATH Enter only one co	ura par fi	ine for (n) (h) and		ohr mrër re	10 110	Sprva	T Mecora	5	LINTE	RVAL BE	TWEEN
		ATH WAS CAUSED BY	D.	ılmonary		and acid	for	duon a	ed seti	110	ONS	Year	DEATH
	002	IMMEDIATE CAUSE (o	,	THUMIALY	turier (CULUSIS	Tar a	iuv aii c	ent acor	V C			
	Conditions, if a	ny which \											8
	gove rise to i	mmediate (
	lying couse lost.	the <u>under-</u>	:)(:										
CERTIFICATION	C.B.S.	HER SIGNIFICANT CON associated	WILL	CONTRIBUTING TO	rauma	with psy	Choti	INAL DISEAS	E CONDITION GI	VEN IN PA	ART 1(o) 1	9, WAS PERFO YES	AUTOPSY ORMED?
	20a ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	AS UNDERLYING D G CAUSE OF DEATH MEDICAL EXAMINER)	20b DES	SCRIBE HOW INJUR	Y OCCURR	ED. (Enter noture o	finjury in I	Part I or Pai	rt II of item 18.)				
MEDICAL	20c. TIME OF INJUR Hour o, m. p m.	RY Month, Doy, Ye 19	ar 20d While at wo		20e. Pl	LACE OF INJURY (I actory, street, office	Home, form bldg., etc	20f. (Cit	y or lown)		(County)	 	(Stote)
	21 I certify the	at (I) (this haspital	l) atten	ded the deceas	sed fram:	April 25,	15 1 01 1 : [ebruary				
	220. SIGNATURE	m-f / /	1 12	1								22	b. DATE
١,	Llenin	bill del	(1)	evilpo.		M.D PHYS.		ED. IRECTOR	STAFF PHYS X			2/]	9/60
6	22c PHYSICIAN S NAME (Type)	Agustin de	1 Cam	po, M.D.		Sprin		Ld Hos	pital, S	ykest	v il le	, Md	l.
23	B IRIA CREMAT C		OF	R HME OF	CEMETERY.	and prest	Been	23d LOCA	TION (C.IV. town,	or county	- lu	(Star	te)
24	FUNERAL DIRECTOR	S SIGNATURE		ADDRESS		~		D BY REGIS			SIGNATUI		
	+ 111	1 /1/11/m	11	1/1/2	0 03	1	DATE I	CED O O	180	Tothur	T & 16	ALLA	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) b. COUNTY Carroll . COUNTY Maryland Carroll MARYLAND funeral director. Pained for your file c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) for your Vrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Mt. Airv Board d STREET ADDRESS . IS RESIDENCE ON A FARM? YES I NOA home - Mt. Airy 3. NAME OF Midd e 4. DATE Month DECEASED 3 to the OF M. (Type or print) JAMES THOMAS DEATH February 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. may b lest birthday) Months and March 17, WIDOWED DIVORCED | Male 10e, LSUAL OCCUPATION (G ve kind of work 10b. KIND OF BUSINESS OR INDUSTRY , 11, B.RTHPLACE (State or fore on country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A.F Baltimore Co. Md. U.S.A. pages PM3 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Justa Witherspoon George 6. Thomas 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Yes no, or unkown) (.tyass interpretates of the color) 214-36-0389 George C. Thomas, Mt. Airy, Md. 18. CAUSE OF DEATH [Enter only one cause par line for (a,, (b,, and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Carbon monoxide poisoning IMMEDIATE CAUSE (a) **DUE TO** (0 DUE TO (a), slating the underlying PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 ... 19. WAS AUTOPSY PERFORMED? 2 NO plnoi 208. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING 1 20b. DESCRIBE HOW INJURY OCCURED. (Entar natura of Injury in Pert I or Part II of Item 18) CAUSE OF DEATH. Asphyriated while working on car in closed garage 20d. NULRY OCCURRED | 20d. NULRY OCCURRED | 20d. NULRY (Home, farm, 20d. (City or lown) 20c, TIME OF NJURY 0 factory, street, office bldg., etc.) While Not While at work at work Mt. Airv. Md. Garage 21. I certify that I took charge of the remains described above, held an Autopsy Inspection K. Inquiry and in my opinion forwarded IL DIRECT Accident . death resulted from: Natural causes Suicide Homicide . Undetermined manner CHIEF MEDICAL EXAMINER DE ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE PUNERAL. DEPUTY DEPUTY MEDICAL EXAMINER 2/22/60 plnous Russell S. Fisher, M.D. Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or country) 226. BUR.AL, CREMATION, 226. DATE THEREOF (State) REMOVAL (Specify) Feb. 24-60 | Pine Grove Cemetery Mt. Airy, 40 9 Carroll Co. Md. 23. FUNERAL DIRECTOR ADDRESS 24a, REC'D BY REGISTRAR I 24b, REGISTRAR'S SIGNATURE VS. A15ME FEB 25'60 arthur & Krons WINFIELD, MARYLAND C. M. WALTZ. 5M 7/59 DATE

MARYLAND STATE DEPARTMENT OF HEALTH



CERTIFICATE OF DEATH 1864

01858

	1. F	PLACE OF DEATH							ENCE (Who	ere decease	d lived. If insti		: Residen	ce before	e admissi	on)
	Carroll MARYLAND							Maryland b COUNTY Balto, City								
	Ŀ	b. CITY OR TOWN (IF	autside carporale limi	ts, write	c LENGTH O	F STAY IN	1Ь	c. CITY OR TO	OWN (If or	itside carpo	orate limits, writ	e RUI	RAL and g			,
		Sykesville)		3mos.	2days	5	850	W. 3	7th S	treet			51	141	1./
	, ,	d. NAME OF HOSPITA		ive street	address)			d. STREET AI	DDRESS					e	IS RESI	
1.5			ld State Ho	ospit	al			Ral	timore	e 11.	Md.				YES 🗍	
	3. 1	NAME OF DECEASED	Fir	st		Middle		lasi		4. DATE		Aanth		Day	Y	ear
		(Type or print)	Maud	de E	arroll	Comp	ton	Tows	on	DEATH	म _ि न	bru	ary	23,	, 1	9 60
	5 5	SEX	6 COLOR OR RACE	7 MARE	RIED T NEVER	MARRIED	_ ,	DATE OF BIRTH		-	9. AGE (In year	"." -	UNDER	- 1		
		Female	White	WIDOWI	ED 🏋 D	IVORCED [August 9	9, 18	87	1 22.00	775.	Months	Days	Hours	Min
I	10p	LSUAL OCCUPATION	N (Give kind of work i	dane 10b	KIND OF BUSI	INESS OR I	NDUSTR	Y 11. BIRTHPLA	ACE (State o	or foreign o	country)		12 CITI	ZEN OF	WHATC	OUNTRY?
		Nurses Aid		'		-		Ma:	ryland	d			U	.S. A		
-/	13.	FATHER'S NAME						14. MOTHER'S	MAIDEN N	AME						
		John Compt	ton					Catl	herin	e Car:	roll					
		WAS DECEASED EVER	IN U.S. ARMED FOR		SOCIAL SECUR	RITY NO.	17, INFC	RMANT			1	ddre	\$\$			
	(102	No	- 705, Gra wor or other or o	2	17-20-6	5772	Sp:	ringfie'	ld Ho	spita.	1 Record	ds				
		1B CAUSE OF DEAT	'H [Enter only one co	use per li	ne far (a), (b),	ond (c)]								INTE	RVAL BET	WEEN
		PART I. DEAT	H WAS CAUSED BY:	, 19	ronchor	meumo	າກາໍລ							-	IVS	DEATH
1		4917	DUE TO		- Landani		2							126		
Canditions, if any, which) (b)																
		gave rise to im cause (a), stating t	mediale Dus TO													
		lying cause last.	(c	1												
	Z O	PART II. OTHI	ER SIGNIFICANT CON	DITIONS	CONTRIBUTING	TO DEATH	BUTIN	OT RELATED TO	THE TERMIN	NAL DISEAS	E CONDITION	GIVE	N IN PAR	T 1(a) 19	WAS A	UTOPSY
)	S S	(/. P.J. 8550	oc.wirm cel	repra	ir artei	TOSCT	rero	SIS WILL	n psy	CHOLL	c reacc	I OI.	r e		YES 🗌	ио 🛅
	CERTIFICATIO	200 ACC DENT WAS	UNDERLYING []	20b DES	CRIBE HOW IN	JURY OCC	URRED	(Enter nature of	injury in P	art Lar Pa	rt II of item 18)					
		(IF EITHER, NOTIFY	MEDICAL EXAMINER)													
	MEDICAL		Manth, Day, Ye					E OF INJURY ()			y ar tawn)		((County)		(State)
	MED	Haur a.m.	19	White of war	k at work		racta	ry, street, artice	olug., etc.	1						
		2) I cartify that	(I) (this haspital	\ cttone	ded the dec	anned fro	om N	ovember	21.0	59	Februar	y 2	310 6	O 16	st (1) /s	val last
		saw the decease	779 7								the causes					
		22a. SIGNATURE	d dive dir	0	/ · ·	7 dild ill	or dec	ALL GEOTIES	, diff.22	perg- in Otti	THE COUSES	ano	dir inc	Julie		DATE
		(10)	Luca -1	1	Lambel	ده	M.	ATTENDING	ME DIE	D. RECTOR	STAFF PHYS IC			2/	123/6	SIGNED
1		22c PHYSICIAN'S						22d ADDRE	SS				_		-27	
		NAME (Type)	Edmund L	usthe	us, M.l	0.		Spri	nofie.	ld Ho	spital,	S	rkesv	1116	e,Md,	
	23o	BURIAL, CREMATION	N, 236 DATE THEREC)F	23c NAME (OF CEMETE	RY OR	CREMATORY		23d. LOCA	TION (City, tax	n, ar	cauniy)		(State)
		REMOVAL (Specify)	12-25-	60	Wa	0 D	1	WM		B	ALTO	, 0	0,			
	24	EUNERAL D RECTOR'S	SIGNATURE		ADDRESS		-47		250 REC'D	BY REGIS			RAR'S SIG	GNATUR	E	
	25	wil E ble	unas Ale	13/1	Salien	7	B	hie.	DATE FE	B 2 4	60	an	thung of	. Kiai	LA.	

may be retained by the haspital at adding physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directar, page 3 should be detached far use as the burial-transit permit. Then please remove carban pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, ar removal, and in any event, within 72 haurs after death havrs after death. Page 4 AN: The law requires that the death certificate be executed wit TO HOSPITAL OR ATTENDING PHYS

VR A15 (4) 1SM 9/59



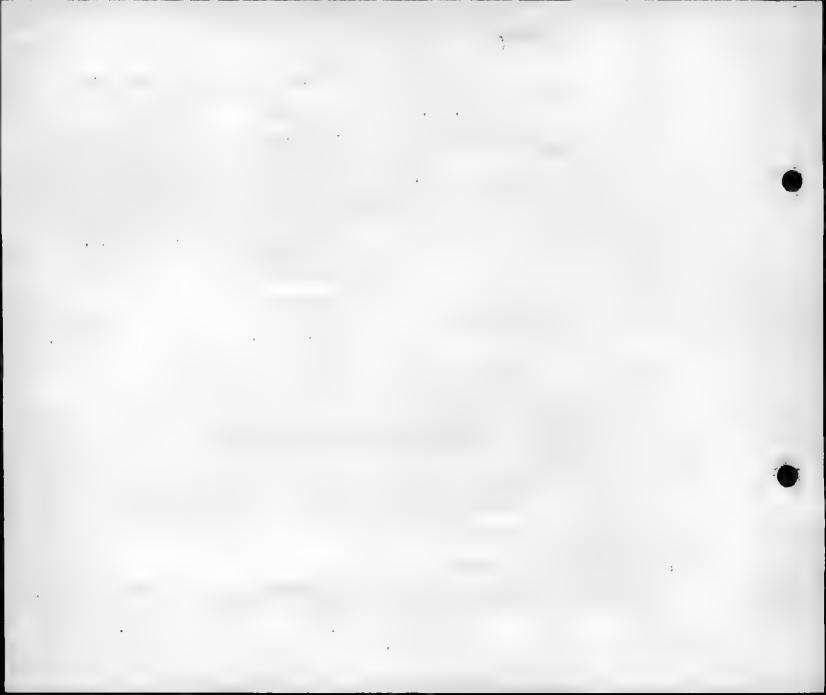
	AND STATE DEPARTMENT C	
DIVISION OF STATIS	STICAL RESEARCH AND RECORDS — BAL	TIMORE 1, MARYLAND
1865	STICAL RESEARCH AND RECORDS — BALL CERTIFICATE OF DEATH	4 .

	PLACE OF DEATH D. COUNTY Carroll	ę		MARYL		a. STATE		ere decease	d lived If institut b. COUNTY			mission)
	b. C.TY OR TOWN (IF	outside carporate limi	ts, write	c. LENGTH OF STAY IN	N Ib	Maryl		utside corpo	rate limits, write I			awn)
	Sykesvill	arest tawn)		Oyr.6mo.8da	il	Balti				01 4	_	,
_	d. NAME OF HOSPITA				-3/	d. STREET AD					e. IS	RESIDENCE
	Springfie	ld State H	ospit	al		3103 M	areco	Aven	ue			N A FARM?
3	NAME OF	Fir		Middle		Lost		4. DATE	Ma	n Ith	Day	Year
	DECEASED (Type or print)	Ja	mes	т.		Tuoh	v	OF DEATH	Februar	У	9	19 60
5 3	SEX	6. COLOR OR RACE	7. MARRI	IED NEVER MARRIED	BD	ATE OF BIRTH			9. AGE (In years			NDER 24 HRS
	Male	White	WIDOWE	D DIVORCED	□ No	vember	6. 19	07	lost birthday) 52 yrs.		pys Hou	urs Min.
00	USUAL OCCUPATIO	N (Give kind of work	done 10b. I	KIND OF BUSINESS OR					ountry)	12 CITIZE	NOFWH	AT COUNTRY?
	Odd job	ing life, even if retired S	,	-		Marv1	and .	Balt	timore	U.S	5.A.	
13.	FATHER'S NAME				1	4. MOTHER'S			<u> </u>		- J 44.J.	-
	James Tuo	hy				Anni	e Sul	livan	ı			
	WAS DECEASED EVER			SOCIAL SECURITY NO	17, INFO	RMANT	-		Add	iress		
Ye	No. or unknown)	Fyes, give wor or dates of s	eux ce)	None	Sn	ringfie	ld Ho	snita	l record	S		
	18. CAUSE OF DEA	TH (Enter anly one co	use per lin	e far (a), (b), and (c).								BETWEEN
		H WAS CAUSED BY-	Tr.	ar advanced	hila	toral r	מת דיני	nome 1	tuisaman l	neie		ND DEATH
	202 X	IMMEDIATE CAUSE (d		<u>a. 807 11060</u>	DILLO	rocrat r	Julino	itor A	og ter care	7919	7.00	ar D •
	Conditions, if on		1									
	gave rise to in cause (o), stating t		,									
	lying couse lost	(c)									
Z	PART II OTH	ER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DEAT	TH BUT NO	T RELATED TO	THETERMIN	NAL DISEAS	E CONDITION GI	VEN IN PART I	(c) 19 W	AS AUTOPSY REORMED?
CATION	Ps	ychosis wi	th Co	nstitutions	al Ps	ychopat	hic F	erson	ality			□ NO □
CERTIF	200 ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	CAUSE OF DEATH	20b. DESC	TRIBE HOW INJURY OC	CURRED. (1	Enter noture of	injury in P	ort I ar Par	t (1 af item 18.)	-		
MEDICAL	20c. TIME OF INJURY	Month, Doy, Ye	or 20d. IN	JURY OCCURRED 2		OF INJURY (H			y or tawn)	(Ca	inty)	(State)
ğ	Haur a.m. p.m.	19	While at work	Nat while	roctory	, street, office	bldg, elc.)				
5				ed the deceased f	.Tı	1137 31	10	20 .	Fehmany	8 10 61	7 45 5 7	1) 7
	22a. SIGNATURE	ed alive an	y 8,60, and 1	in accurred	Odto Th	MA, • PROM	the causes a	nd an the	date sta	22b. DATE		
	177 - 2 - 1	in del 6	At D	ATTENDING MED STAFF \$IGNE								
	22c PHYS CIAN S	W D	PHYS 22d, ADDRES		RECTOR [LH12 PM		~_~~	79/00			
./	KIMAR /T	gustin del	Самр	0				ield H	lospital,	Sykes	ville	, Mi.
23c	BURIAL, CREMATION	N. 23b. DATE THEREC)F	23c NAME OF CEMET	TERY OR C	REMATORY		23d. LOCA	TION (City, tawn,	or county)	(State)
	Bur isgerfy)	2/12/6	C	New Catl	hedra	al Cem		Ba:	ltimore	. Md.		
24-	FUNERAL DIRECTOR	SIGNATURE	nek 1	Funderal Ho	ome		250 REC'E	BY REGIST		ISTRAR'S S GN	IATURE	
7	331 Breh	ms Lane	IOA. I	WHOLAT III	0 2110		DAFEB	11'60	Ont	lour S. Ku	Assu	
-												

TO HOSPITAL OR ATTENDING PHYMAN: The law requires that the death certificate be executed with the haurs after again. Tage was been required that the control of the harpital by the following the harpital by the following physician and gampitely filled in by the funancial director, page 3 should be detached for use as the buno-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Bealth prior to burief, camation, or removal, and many event, with the State Board of Bealth prior to burief. 12 P

5

VR ATS (4) 15M 9/59



MARYLAND

g. STATE

Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. COUNTY

Baltimore City

PLACE OF DEATH

Carroll

o. COUNTY

24 Filled death. campletely papers. gud b c physician

attending please the ģ gned physician. been si burial-transit

that the death certificate be

0 IVERAL DESCTOR: to Board shau d m 9 **VR A15 (4)**

b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) 6mo. 17days Baltimore Svkesville d NAME OF HOSP TAL (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE OR INSTITUTION ON A FARM? Springfield State Hospital YES NO W 4315 Harford Road Middle 4. DATE Yeor DECEASED (Type or print) DEATH Franklin February 1960 Henry Wagner 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH AGE (In years IF JNDER 1 YEAR IF JNDER 24 HRS lost birthday) Months DIVORCED [76 WIDOWED TO yrs Male 10a USJAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Employee B.&O.R.R. U.S.A Marvland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Amelia Henry Herman Wagner IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO 17. INFORMANT Address Springfield Hospital records No None 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (6) Arteriosclerotic heart disease vears DUE TO Conditions, if ony, which Coronary arteriosclerosis vears gove rise to immediate DUE TO couse (a), stating the under-Bronchopneumonia davs tying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY C.B.S. associated with cerebral arteriosclerosis, with psychotic reactives No 200 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part | of Item 1B) 20c. TIME OF INJURY Month. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f (City or town) (State) (County) factory, street, office bldg., etc.) o. m While Not while of work of wark 21 | certify that (1) (this haspital) attended the deceased from July 24 1959, to February 11960 that (1) (we) lost saw the deceased glive on February 109, 60 and that death accurred a 100 50 Atriba the causes and on the date stated above. 22a SIGNATURE 22b, DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS TO PHYS. 22c PHYSICIAN S NAME (Type) 22d ADDRESS Agustin del Campo. Springfield State Hospital, Sykesville, Md. 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23d LOCATION (City, town, or county) (State) REMOVAL (Specify) Baltimore, .oudon em. burral 25b. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR Hartord Kd



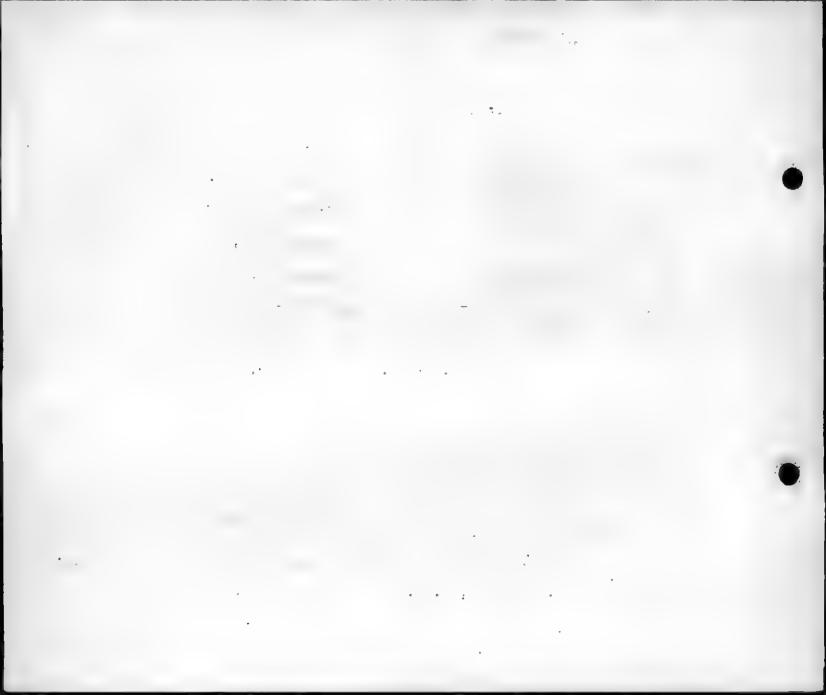
r death.

VS A1S (4) 1SM 9/S8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

		1867	CERTIFICA	ATE OF DEATH	1	Reg. Dist.	No. 74
1	PLACE OF DEATH	oll	MARYLAND	2. USUAL RESIDENCE (Who STATE Maryl	- h C	OHNTY -	before admission)
	b. CITY OR TOWN (If outside corp	orate limits, write	c LENGTH OF STAY IN 16	E. CITY OR TOWN (If o	utside corparate limits,	write RURAL and give	e negrest lown)
	RURAL and give nearest town)	Henryton	230 days	Prest	on	OJX-	nt-a
	d. NAME OF HOSPITAL (If not in I			d STREET ADDRESS	-	007	e IS RESIDENCE ON A FARM?
		ton Stat	e Hospital	Route	1, Box 3	9	YES NO 1
3.	NAME OF DECEASED (Type or print)	fint Minnie	Middle Grace	losi We bb	4. DATE OF DEATH FIGH	Month ruary	Day Year 8 19 60
S.	SEX 16. COLOR C		RIED T NEVER MARRIED	8. DATE OF BIRTH	9 AGE II	n years IF UNDER 1 Y	EAR IF UNDER 24 HRS
	Female Negr			9-22-70 890	1899 3690	thdoy) Months De	oys Hours Min.
10	usual Occupation (Give kind during most of working life, even	of work done 10b.	KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (Slote	or foreign country)	12 CITIZE	N OF WHAT COUNTRY
	None	ii remedj		Federalsb	urg. Mary	land	USA
13.	FATHER'S NAME			14. MOTHER'S MAIDEN N			
	Dani	el Hubba	rd		Eliza XXX	x Murray	
15	WAS DECEASED EVER IN U.S. AR			INFORMANT		Address	
1.	No.		19-01-9432	Brace Webb -	Same as p	atient	
	18. CAUSE OF DEATH [Enter or	ily one couse per li	ne for (o), (b), and (c).]				INTERVAL BETWEEN
L	PART I DEATH WAS CAU	SED BY	ardiovascular	rinsufficien	cv		ONSET AND DEATH
	002x	DUE TO				-	
	Conditions, if any, which)	" Far	adv. bilat.	pulmonary th	c. T cavi	tv right	
	gove rise to immediate	DUE TO				-,	
ı	lying cause lost.	(4)					
CERTIFICATION	PART II OTHER SIGNIFICA	ANT CONDITIONS C	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM!	NAL DISEASE CONDIT	ION GIVEN IN PART 1	(o) 19 WAS AUTOPSY PERFORMED? YES NO
ERTIFIC	20g ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE O	G 206 DES	CRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in I	Port 1 or Port II of item	18.)	
	(IF EITHER, NOTIFY MEDICAL EXA		- [
MEDICAL	20c TIME OF INJURY Month Hour o. m.	While		LACE OF INJURY (Home, form actory, street, office bldg., etc.	20f (City or town)	(Cou	inly) (State
M.E.	p. m.	19 of wor					
	21. I certify that I attend	ded the deceas	ed fram June 23	3 , 19. <u>59</u> , to Fe	bruary 8	19 60hat 1 last	saw the deceased
	alive on February	8 , 19	60 , and that death	occurred at 8:35A	M, from the cau	ses and an the c	late stated above
	8.				ADDRESS (Street, city of		DATE SIGNED
	ACTUAL BLEANS	11. Man	lacery M. D.	M.D. Henryt	on, Maryl	and	2-8-60
	PHYSICIAN'S Edgars M	I. Macula	ns, M. D.	Henryt	on State	Hospital	
22	BURIAL, CREMATION, 226. DAT		22c NAME OF CEMETERY C		22d. LOCATION (City Near Pres	ton, Maryl	(Stole)
23	FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		D BY REGISTRAR 24	b. REGISTRAR'S SIGN	ATURE
	J.J. Framplow	Jn	Federalsburg,	Maryland DAREB	1 5 '60	CINTLANT S. Hra	u.A



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01862

1868

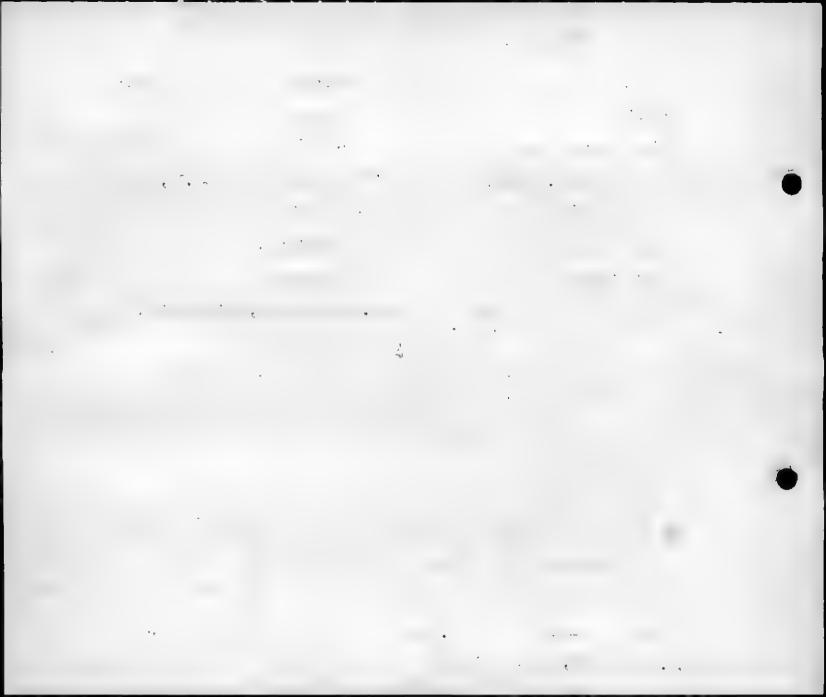
			MA	RYLAND	o. STATE		re deceased	b. COUNTY	n: Residen	,	odmission)	
b CITY OR TOWN (IF RURAL and give neo Woodbine d. NAME OF HOSPITA	irest town)		c. LENGTH OF STA	AY IN 1b		ott C		te limits, write R	URAL and g	/2 X	IS RESIDE	NCE
OR INSTITUTION	ursing Hor		,		Clarksv						ON A FA	RM7
NAME OF DECEASED	Fi	rst	Midd	dle 1	1) = Last		4. DATE OF	Man		Day	Year	e
(Type or print) 5. SEX	LTAM HAVED			PARTO I	B. DATE OF BIRTH	au	DEATH	F.b.18	1,960	1 YEAR IF	UNDER 2	24 HRS
Male	White	WIDOWE	RIED NEVER MAR ED T DIVOR	CED	May 29.1]	lost birthdayl	Months			Min.
IOO. USLAL OCCUPATION	N (Give kind of work ng life, even if retired	done 10b	KIND OF BUSINESS	OR INDUS	TRY 11. SIRTHPLA	CE (Slote o	Md		12.CITI	ZEN OF W	HATCOU	NTRY
Levi Wid	lerman				Unl	nom						
(Yes, no. or unknown) (H	IN U.S. ARMED FOR yes, give wor or dofes of	RCES? 16.	SOCIAL SECURITY I	NO. 17 IN	FORMANT	*	.,	7 1 n Addi	ress" .			
PART I, DEAT	H (Enter only one of H WAS CAUSED BY- IMMEDIATE CAUSE (c	ouse per lin	ne for (a), (b), and (ere , a	Terr	nclu	oui	ty,16		AL BETW AND DE	
Canditions, if on gave rise to im cause (o), stating the lying cause lost.	y, which (to mediate)	0	merely	ed,	Currel	rel	pne	emon	za	18	Fek (60
		ID. YIMA IC C										
PART II. OTHI	ER SIGNIFICANT CON								EN IN PAR		WAS AUT PERFORMI ES N	ED?
PART II. OTHE	UNDERLYING []		CRIBE HOW INJURY						EN IN PAR		PERFORM	ED?
PART II. OTHE	UNDERLYING D CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY	OCCURRED		injury in Pa	ert or Port	II of item 18.}			PERFORMI ES N	NO 🗌
20c TIME OF INJURY Hour o. m. p. m 21 1 certify that saw the decease	UNDERLYING CAUSE OF DEATH AEDICAL EXAMINER) Month, Doy, Ye 19	20b. DESC or 20d. It While of wor	CRIBE HOW INJURY NJURY OCCURRED Not while of wark	20e. PLA faci	O. (Enter nature of NCE OF INJURY IN tory, street, office	injury in Polome, farm, bldg., etc.)	20f. (City	or town)	, 19_6	County)	PERFORMI ES N	(State
20c TIME OF INJURY Hour o. m. p. m 21 1 certify that	UNDERLYING CAUSE OF DEATH AEDICAL EXAMINER) Month, Doy, Ye 19	20b. DESC or 20d. It While of wor	CRIBE HOW INJURY NJURY OCCURRED Not while of wark	20e. PLA faci	CE OF INJURY (Hotory, street, office	injury in Polome, farm, bldg., etc.)	20f. (City of the control of the con	or town)	, 19_6	County)	(I) (we tated at 22b D	(State
20c TIME OF INJURY Hour o. m. p. m 21 1 certify that saw the decease	UNDERLYING CAUSE OF DEATH AEDICAL EXAMINER) Month, Doy, Ye 19	20b. DESC or 20d. It While of wor	CRIBE HOW INJURY NJURY OCCURRED Not while of wark	20e. PLA faci	CE OF INJURY (Hotory, street, office	injury in Police injury in Police injury in Police in Police in Police injury injury in Police injury	20f. (City of A., from 1	Il of item 18.) or town) he causes an	, 19_6	County)	(I) (we	(State
20c TIME OF INJURY Hour o. m. p. m 21 1 certify that saw the decease 220 SIGNATURE 22c PHYSICIAN'S	UNDERLYING CAUSE OF DEATH AEDICAL EXAMINER) Month, Doy, Ye 19 (I) (this hospita and alive an	20b. DEScor 20d. It White of wor 1) attend	CRIBE HOW INJURY NJURY OCCURRED Not while of wark	20e. PLA fact and that de	CE OF INJURY INtory, street, office eath accurred ATTENDING PHYS. 22d. ADDRE	lome, farm, bldg., etc.) 2 . 19_ at/	20f. (City of the control of the con	Il of item 18.) or town) he causes an	d on the	County)	(I) (we	(State)

may be retained by the hospital of ding physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fulled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, or remayal, and in any event, within 72 peac, after death. 4 hours after death Page 4 ■■: The law requires that the death c≡tificate be executed with TO HOSPITAL OR ATTENDING PHY

1

VR A1S (4) 1SM 9/59



01863

Reg. Dist. No.

2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. COUNTY Allegany c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO IX Month 60 19 IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years last bighday) Months 12. CITIZEN OF WHAT COUNTRY? U.S.A. Alice V/ Beardsley Address Hospital records, Springfield State Hosp. INTERVAL BETWEEN ONSET AND DEATH H WAS CAUSED BY. Asphyxia due to obstruction of both bronchi by food. hours years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES PA NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Part 11 of item 18.) MEDICAL 20c. TIME OF INJURY Month. 20e, PLACE OF INJURY (Hame, farm, Day. Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) factory, street, affice bldg., etc.) Haur a. m. While Not while at work at wark p. m. 21. I certify that I attended the deceased from Nov. 18 Feb. . 1960 that I last saw the deceased and that death accurred at 6:115M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Sykesville, Maryland SIGNATURE PHYSICIAN'S Konstantin Weber. M. D. NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) (Stote) 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 8/60 Beallsville Burial Monocacy 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE arthur S. Krous

0.56 by the haspital may be retained by the haspital
TO FUNERAL DIRECTOR: After th
page 3 shauld be detached far VS A15 (4) 1SM 9/SB

prior

the registrar

hours after death.

death certificate be executed

the thot t

ACTION OF BUILDING ADDITION OF THE PARTY 4 ... W . CATAMA TO THE PARTY OF THE PARTY. - A . • and the second s ALL THE SECOND STREET, SECOND

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1870 CERTIFICATE OF DEATH

Reg. Dist. No. 1864

1	
	o. COUNTY Ollie MARYLAND 2. USUAL RESIDENCE (Where deceased lived). If institution: Residence before admission) o. STATIMULT COUNTY Collically
	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruschester Rusal 20 4ss Manual 20 4s
	d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION e. IS RESIDENCE ON A FARM? YES \(\) NO
3	3. NAME OF DECEASED (Type or print) WILLIAM - A TEPP DEATH FLOW 28 1960
1	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH WIDOWED DIVORCED APT 11-1887 9. AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
	100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) Lus A 12. CITIZEN OF WHAT COUNTRY?
1	Jacob Repp. 14. MOTHER'S MAIDEN MAME Kerchicay
	15. MAS DECEASED EVER IN U. A ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (If yes, gift yes,
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Carcinoma of the Stomach INTERVAL BETWEEN ONSET AND DEATH 1/4, INO
	151X DUE TO
	gave rise to immediate couse (a), stating the under lying couse lost.
)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Haur o. m., p. m. 19 of work
	21. I certify that I attended the deceased from 2/21, 1960, to 2/28/, 1960, that I last saw the deceased alive an 2/28/60, 19, and that death accurred at 1 p. M. from the causes and on the date stated above.
	ACTUAL SIGNATURE M.D. Hampstead, Md. 2/29/6
	PHYSICIAN'S M. C. Porterfield / NAME (Type)
1	120. BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stole) - The following of County) (Stole) - The following of County)
2	Edel Chipton Hampstead Mydate MAR 2 '60 24b. REGISTRAR'S SIGNATURE COLOR MAR 2 '60

TATOR STANDARDS OF STANDARDS have the first the sould need the state of the SE WILLIAM - A - SERVITE RESIDENCE Faller of market grand of Herrison Marie - and all the things of the second Allow of the sealest of A PARTY TO LOCALLY LOCAL STATE OF THE STATE Placement Mars 2 - 60 Littleman Marchester Elmerthering Elmerther and the first the state of the state of the